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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12218 12229 CERTIFICATE OF DEATH TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. the funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. STATE Maryland o. COUNTY
Carroll MARYLAND Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

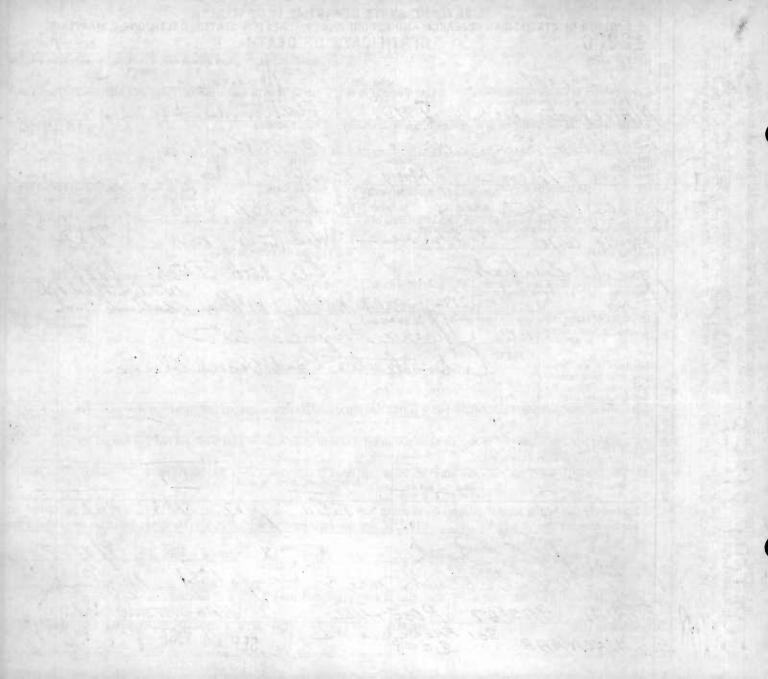
Sykesville c. CITY DR TOWN (If autside corparate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 in by 30vrs. 10mos. hdvs. Cumberland d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS filled 408 Washington St. NO TX SpringfieldState Hespital NAME OF Middle 4. DATE campletely and a Year DECEASED MARGARET Opie ANNAN (Type or pnnt) DEATH SEPTEMBER IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6. CDLOR OR RACE NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years 7. MARRIED 89 lost birthdoy) Months 6-19-1878 White Female ar remaval, and in any WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) None COUNTRY? Cumberland. Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Daniel Annan Virginia Butcher 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) 215-56-1383 Records, Springfield State Hospital INTERVAL BETWEEN ONSET AND DEATH Days 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit PART I. DEATH WAS CAUSED BY Bronchopneumonia IMMEDIATE CAUSE (o) DUE TO burial, Conditions, if ony, which gove (b) rise to immediate couse (a). DUE TD stoting the underlying couse priar ta has been Arteriescleretic heart disease Years RART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Schizophrenic reaction, paranoid type 19. WAS AUTOPSY PERFORMED? Health p NO DE this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e. PLACE OF INJURY (Home, farm, 20c. TIME DF INJURY Month, Day, Year 20d. INJURY OCCURRED (City or town) (County) (Stote) Hour 'o.m. foctory, street, office bldg., etc.) Not While TO FUNERAL DIRECTOR: After 21. I certify that (I) (this hospital) attended the deceased fram 11-2-36 that (1) (we) last 50PM, from causes and an the date stoted above. be retained saw the deceased alive on 9and that death accurred at 22b. DATE SIGNED ATTENDING X 9-6-67 director, page 3 shauld be filed v M.D. DIRECTOR 22d. ADDRESS Springfield State Hospital AME (Type) Agustin del Campo. M. Sykesville, Maryland 230. BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b DATE THEREOF (County) (Stote) REMOVAL (Specify) Rose Hill Cemetery Allegany 9/8/67 Cumberland Md. 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE **ADDRESS** 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 H. Wayne George Cumberland, Maryland 8 1967 DATE

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 1221.3 12230 CERTIFICATE OF DEATH 24 haurs after death and attending physician and campletely filled in by the funeral permit. Then please remave carbor papers, Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY b. COUNTY Maryland Carroll MARYLAND b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) write RURAL and give nearest tawn) Sykesville Baltimore 2 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM 3905 Oakford Avenue Springfield State Hospital YES NO X law requires that the death certificate be executed within NAME OF First Middle 4. DATE Year Day DECEASED OF JAMES **PURVISS** ARTHUR 19 (Type ar print) DEATH SFX IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE B. DATE OF BIRTH AGE (In years 7. MARRIED **NEVER MARRIED** last birthday) Haurs 03-05-12 Male Negro WIDOWED DIVORCED 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during mast of warking life, even if retired) COUNTRY? INDUSTRY South Carolina U.S.A Laborer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remaval, Elizabeth Taylor, deceased Rubin Arthur, deceased 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yes, na, ar unknawn) (If yes give war ar dates af service D 226-18-4220 Hospital Records No crematian, 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH Huntington's Chorea. IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave Toxicity due to infected decubitus ulcers. months (b) rise ta immediate cause (a), DUE TO stating the underlying cause as the be retained by the haspital ar attending has been last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1/01 CBS as or, with diseases of unknown or uncertain causes, Huntington's 19. WAS AUTOPSY PERFORMED? far use Health YES T NO chorea, without qualifying phrase. Parkinsonism. TO FUNERAL DIRECTOR: After this certificate 20g. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached te Dept. af (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Hame, farm, 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED (City or town) (County) (State) factory, street, affice bldg., etc.) Hour a.m. Nat While State at wark at wark . 19 67, that (I) (we) lost 21. I certify that (I) (this hospital) attended the deceased from 19 \_\_\_\_, and that death occurred at 1.05 M, from couses and on the date stated above. sow the deceosed olive on 9-15-67 22b. DATE SIGNED 22a. SIGNATURE MED. DIRECTOR STAFF PHYS. ATTENDING 9-16-67 M.D. PHYS 22d ADDRESS Springfield State Hospital, Sykesville AJONCHERE NAME (Type) directar, shauld be 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, or Town) (State) BURIAL, CREMATION, (County) REMOVAL (Specify) 24. FUNERAL DIRECTOR ADDRESS 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) DATSEP

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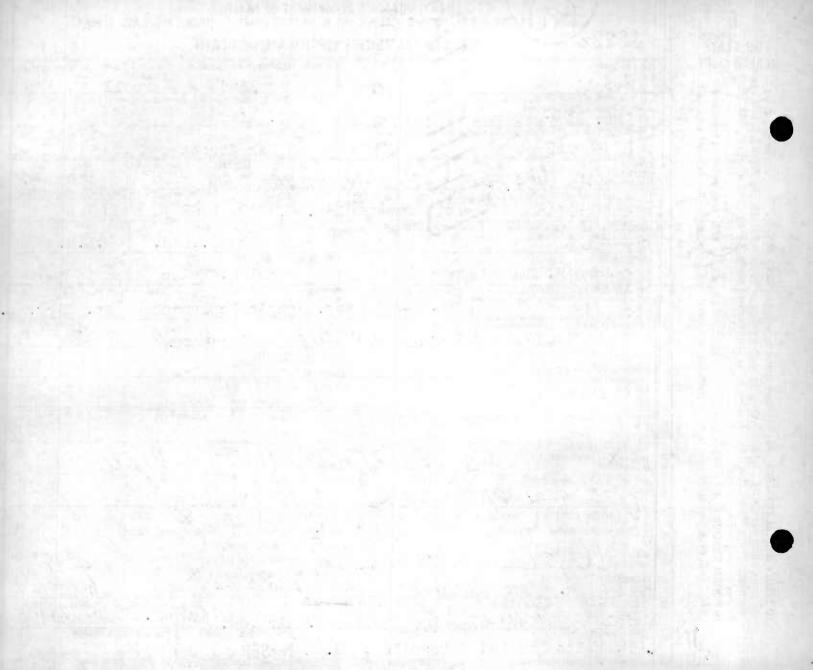
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	E.S. MACNABB 301 FREDERICK Rd OATE SEP 14 1967	276
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## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission) a. COUNTY h. COUNTY CARROLL MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c, CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) write RURAL and give nearest town) NESTMINSTER RT#6 WESTMINSTER d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? CARROLL CO. GENERAL SMALLWOOD YES NO 4 3. NAME OF completel 4. DATE Month Yeer DECEASED OF (Type or print) BARKSDALE DEATH 196/ 6. COLOR OR RACE 7. MARRIED FREVER MARRIED 5. SEX 8. DATE OF BIRTH 9. AGE (in years | IF UNDER 1 YEAR IF UNDER 24 HRS. and last birthday) Months WIDOWED DIVORCED T 10s. USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) LARGE CHATHAM 1/A 4.5.0 CONSTRUCTION 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME CHARLES RARKS 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unkown) | (Ifyesgivewarordatesofservice) 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY PULMONARY HEMORRAGE MINUTES IMMEDIATE CAUSE (a) DUE TO BROWCHO GENIC Conditions, if eny, which 1 VEAR gave rise to immediate cause DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(+) 19, WAS AUTOPSY CERTIFICATION PERFORMED? NO 20e. ACCIDENT WAS UNDERLYING 2Db. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Pert II of item 18.) OR CONTRIBUTING [ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED | 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) While Not While Hour e.m. et work at work 21. I certify that (1) (this hospital) attended the deceased from P/P... to 9//5 1967, that (I) (we) last saw the deceased elive on 9/15 1967, end that death occurred at P.M. from the causes and on the date stated above. 22a SIGNATURE ATTENDING PHYS. DIRECTOR PHYS. M.D. HOSPITAL 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) director, be filed 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23a, BURIAL, CREMATION, | 23b. DATE THEREOF (Stete) REMOVAL (Specify) 0 AUNERAL DIRECTOR'S SIGNATURE ADDRESS VR A15 (4) 1SM 7/61

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12222MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. I. PLACE OF DEATH USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH DF STAY IN 1b c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) after Years Mt. Airv d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e State Der 72 haurs along with farm ON A FARM? Oak Street Oak Street NO 3 24 haurs after death. 3. NAME OF First Middle 4. DATE Year DECEASED DEATH 5. SEX 9. AGE (In years IF UNDER DATE OF BIRTH IF UNDER NEVER MARRIED last birthdoy) Months Doys Hours White Male 8,1898 Nov. WIDOWED DIVDRCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
Carpenter INDUSTRY COUNTRY? Frederick Co., Md. the Chief Medical Examiner pencil 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME This certificate should be executed within John M. Baumgardner Pearl M. Fritz ond 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY ND Address (Yes, no, or unknown) (If yes give wor or dotes of service) remaval, Mrs. Margie McClenaghan Mt. 18. CAUSE OF DEATH (Enter only one couse per line follo), (b), ond (c).) INTERVAL PART ! DEATH WAS CAUSED BY: o IMMEDIATE CAUSE (o) crematian, DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse burial, WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION YES 🗍 its designated agent, priar ta pe 20o. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. (Enter nature of injumy in Portal of Port II of item 18) PLACE DF INJURY (Home, form, (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg. ot work 21. I certify that I taak charge of the remains described above, held an Autopsy Inspection X Inquiry and in my apinian far Suicide XI. death resulted from: Natural causes Undetermined manner Homicide | CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER [ SIGNATURE O DEPUTY a **EXAMINER'S** Health ( Sne NAME (Type) cher the 23b. DATE THEREOF 23c. NAME OF CEMETERY CO. CREMETER BURIAL CREMATION. 0 Pine Grove 24. FUNERAL DIRECTOR 25b. REGISTRAR'S SIGNATURE VR A15ME (5 Waltz Box 241 Sykesville, Md. Charles 6M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12223 CERTIFICATE OF DEATH 12234 The law requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) attending physicion ond completely filled in by the funerol bermit. Then please remove carbon papers. Poges 1 ond on, or removal, ond in ony event, within 72 hours after deat 1. PLACE OF DEATH o. COUNTY a. STATE b. COUNTY Carroll Allegany Maryland MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural—Sykesville CLENGTH OF STAY IN 15 c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn) Cumberland ly. 9m. ld. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 10 Massachusetts Avenue YES | NO T 3. NAME OF Middle 4. DATE Day Year DECEASED 18 Janet Louise Bealky 19 67 DEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. SEX 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED 25 vrs Manths Days Hours 5/20/42 WIDOWED white DIVORCED female 12. CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? **YATZUGAL** Maryland -Cumberland USA none 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Ella Davis Robert Bealky, Sr. 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) Springfield Hospital records, Sykesville, Md. no none 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) INTERVAL BETWEEN ONSET AND DEATH burial-tronsit PART I. DEATH WAS CAUSED BY: Pneumonia IMMEDIATE CAUSE (a) signed by DUE TO buriol, Toxemia due to infected decubitus ulcers weeks Conditions, if any, which gave rise to immediate couse (o), DUE TO stating the underlying cause FUNERAL DIRECTOR: After this certificate has been as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES 🖃 NO deficiency, idiopathic, severe, with behavioral reaction. the hospital or for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II af item 1B.) 20o. ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Dov. Year factory, street, office bldg., etc.) Not While , 19.65 , ta\_ 9/18/ , 19 67, that (# (we) last 21. I certify that (# (this haspital) attended the deceased fram\_ 12/17/ Poge 4 moy be retoined 1967, and that death accurred at 6215 M, Abhr causes and an the date stated above 9/18/ saw the deceased alive on\_ 22b. DATE SIGNED 22g. SIGNATURE ATTENDING 9/18/67 drover DIRECTOR director, poge 3 should be filed v Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Edmee J. Reeves, M. D. Sykesyille. Maryland 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 230. BURIAL, CREMATION, 23b. DATE THEREOF (County) Burry AL (Specify) Sunset Memorial Park Sept.21,1967 Cumberland, Md. Allegany 9 James F. Scarpelli, Cumberland, Md. 250. SEC BBY REGISTRAR 5 SEGNATURE DATE DATE DATE OF THE PROPERTY OF THE P 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

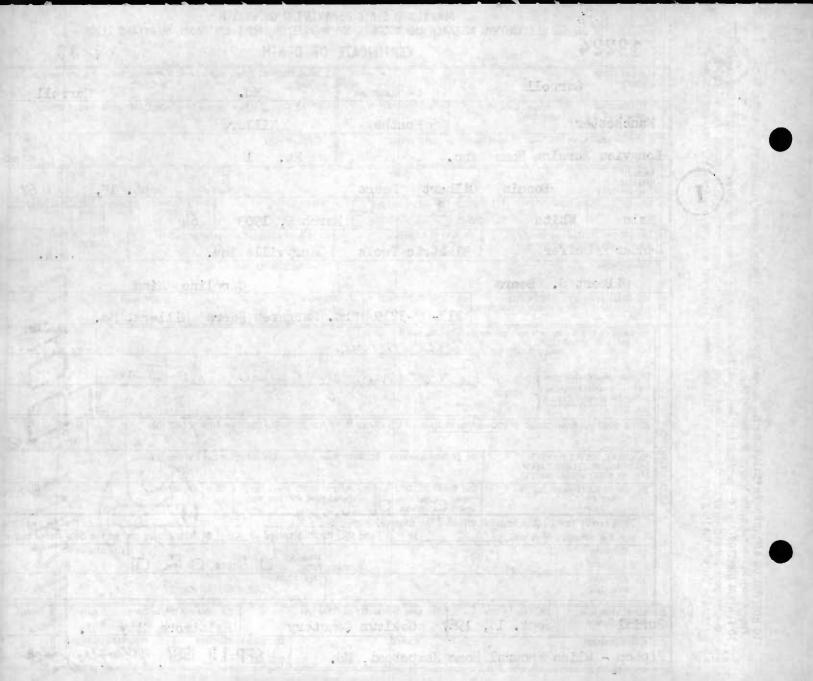
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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his eta Deg	MEDICAL	2Dc. TIME OF IN	JURY Month, Doy, Yeor	20d. IN White	JURY OCCURR Not Wh		LACE OF INJURY (For octory, street, office		2Df.	(City or town)	10	ounty)	(	Stote)
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ES 68 ()		BURIAL, CREMAT		REOF	23c. NAME	OF CEMETERY C	R CREMATORY		23d. LC	CATION (City of	lown)	(County	) (5	tote)
To FUNERAL DIRECTOR.  director, page 3 should be filed with the	Bu	TEMOVIL (Speci	Sept.	18, 196	7 08	aklawn (	Cemetery		Bal	timore (	City	Md.		
= 111		FUNERAL DIRECT				RESS		2Sa. REC'D	BY REGIST	RAR 2Sb.	REGISTRAR'S			THE
VR A15 (4) 20 M 1/66	Ti	pton -	Eline Funera	al Home	Hamps	stead, 1	Md.	DATE SE	P 19	1967	golia	res	Judg	L

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please removerarbon papers. Pages 1 and director, pages 1 should be filed with the State Dept. of Health prior to burial, cremation, ar remaval, and in any event, within 72 hours after dea Page 4 may be retained by the haspital ar attending physician.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12225 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY Carroll Carrell b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b ofter ( Rural - Sykesville 1 vr. 8 mos Westminster. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspitol, give street oddress) d STREET ADDRESS within 72 hours ON A FARM? Springfield State Hospital Route # 7 Box 295-B YES IN NO [ 24 hours ofter deoth. 3 NAME OF Middle 4 DATE Month (Type or print) THOMAS BLANCHARD September 19 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In veors lost birthdoy) Months 9-17-1890 DIVORCED WIDOWED Male White 12. CITIZEN OF WHAT COUNTRY? 10o. USUAL OCCUPATION (Give kind of work done 10h KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) during most of working life, even if retired) INDUSTRY SStationery Engineer Baltimore, Maryland Chemical Co. pencil 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME William Blanchard Margaret Shelby ond 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 17 INFORMANT 16. SOCIAL SECURITY NO. Address removal. 215-03-2618 Redords, Springfield State Hospital 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c), INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY JD. IMMEDIATE (AUSE (6) Bilateral bronchopneumonia This certificate should e, writing the word forwarded to the CP cremotion, DUF TO Canditians, if any, which gave (b) Healed myocardial infarct months rise ta immediate couse (a), stoting the underlying couse (c) Coronary arteriosclerosis vears PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

Healed fracture of head of right femur.

Chronic brain syndrome with senile brain disease with psychotic reaction YES X

200. EXTERNAL CAUSE WAS

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) WAS AUTOPSY PERFORMED? please execute the certificate, its designated agent, prior to PRIMARY Or CONTRIBUTING CAUSE OF DEATH. 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) Hour o.m. factory, street, affice bldg., etc.) Nat While 21. I certify that I took charge of the remains described above, held an Autopsy and in my opinion Inspection . Inquiry [ death resulted fram: Natural causes K Accident Suicide . Hamicide | Undetermined monner CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE 0 DEPUTY MEDICAL EXAMINER **EXAMINER'S** W. Glenn Speicker, M. 5 may b 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION 23b. DATE THEREOF REMOVAL (Specify) 9/23/1967 Cedar Hill Cemetery, A Burial 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A15ME (\$) George J. Gonce-4001 Ritchie Hgwyl, Baltimore 6M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH death. pup 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH o. County Carroll Maryland attending physician and campletely filled in by the for permit. Then please remave carbon papers. Pages 1 MARYLAND please remave carbon papers. Pages 1 I, and in any event, within X2 hours after c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest town)
Sykesville da. Hampstead certificate be executed within 24 haurs yr. 10 mo. 19 e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS Springfield State Hospital 16 South Main Street NO DC 3. NAME OF First 4. DATE Year DECEASED Blizzard 67 Harry Luther September 19 (Type or print) DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 6. COLOR OR RACE B. DATE OF BIRTH 7. MARRIED NEVER MARRIED birthdoy) Days Hours 9-12-1882 White Male WIDOWED DIVORCED 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY Maryland USA Carpenter (retired Carpentry 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John Wesley Blizzard Mary Ann Belt IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT law requires that the death permit. (Yes, no, or unknown) (If yes give wor or dotes of service P 217-12-1924 Springfield Hospital Records No crematian. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY: ONSEL AND DEATH Lobar pneumonia IMMEDIATE CAUSE (o) physician DUE TO signed t Chronic mitral heart disease vears Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the hospital or attending TO FUNERAL DIRECTOR: After this certificate has been as the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) for use CBS associated with Senile Brain Disease with psychotic reaction YES X NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II af item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year factory, street, office bldg., etc.) Not While ot work at work 19 65. to 9-7-, 19 65 that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased from 8-20shauld 19.65, and that death accurred at 5:25PM, from causes and on the date stated above. saw the deceased alive an 9-7-22b. DATE SIGNED 22o. SIGNATURE 9-8-67 X M.D. DIRECTOR PHYS. director, page 3 should be filed PHYS. 22d. ADDRESS 22c. PHYSICIAN'S Springfield State Hospital NAME (Type) Heinz Klaatsch. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 23b. DATE THEREOF (County) 23o. BURIAL CREMATION. BIPEMOVAL (Specify) Sept. 10. Shiloh Cemetery Hampstead Carroll Co. Md. ADDRESS 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) Tipton - Eline Funeral Home Hampstead, Md. 20 M 1/66

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If Institution: Residence before edmission) a. COUNTY b. COUNTY Carroll arvland MARYLAND 27 b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) write RURAL end give nearest town) Rural Taneytown Rural Tanevtown 2. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) d. STREET ADDRESS Route papers. completely 3. NAME OF First Lest 4. DATE Middle Month DECEASED OF (Type or print) DEATH Mamie Esther Bollinger AGE (In yeers | IF UNDER 1 YEAR | carbon With 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH last birthday) and Months WIDOWED Female DIVORCED TO March 1, 1892 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY I II 12. CITIZEN OF WHAT COUNTRY BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired U.S.A. Housework Own home Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME please affending Bollinger Joel Ada Virginia Zent 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 1 17. INFORMANT Address (Yes, no, or unkown) | (If yes give war or dates of service) Mrs. Kennth McKinney, Taneytown, Maryland R.D.1 signed by the 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c) attending physician. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which (b) gave rise to immediate cause DUE TO (e), stating the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6)1 19. WAS AUTOPSY CERTIFICATION 35 0 USB 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Pert I or Pert II of item 18.) 20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached for (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) 20c. TIME OF INJURY Month, Dey, Yeer fectory, street, office bldg., etc.) While Not While Hour a.m. at work et work p.m CIOR: 21. I certify that (I) (this hospital) attended the deceased from. .f., and that death occurred a5 should alive on A.M., from the causes and on the date stated above. saw the deceased 22. SIGNATURE ATTENDING K PHYS. DIRECTOR PHYS. M.D. death. Page 4 O FUNERAL 22d. ADDRESS 22e. PHYSICIAN director, be filed 23a, BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION Tity, town or county REMOVAL (Specify) 0 Buria .1967 Reformed Cemetery Tanevtown, Maryland 1 3 19676. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS A1S DATE

Taneytown, Maryland

RYLAND STATE DEPARTMENT OF HEALTH

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19. that (I) (we) last

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22b. DATE

(State)

SIGNED

IF UNDER 24 HRS.

ON A FARM? YES NO

24 hours after The law requires that the death certificate be

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12228 12239 CERTIFICATE OF DEATH death requires that the death certificate be executed within 24 hours after death and physician and completely filled in by the funeral en please remove, carbon papers. Pages 1 and ). PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission g. COUNTY a. STATE b. COUNTY Carroll MARYLAND Baltimore, MdL b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest tawn) c. LENGTH OF STAY IN 1b Sykesville, Md. Tyr. 3Mos. Baltimore Maryland d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital Mill? Fairview Ave YES NO Y 3. NAME OF Middle Last 4. DATE Manth Day Year DECEASED Joseph Mariom Booker DEATH TF UNDER 1 YEAR IF UNDER 24 HRS. SEX 6. COLOR OR RACE 8 DATE OF BIRTH 9. AGE (In years NEVER MARRIED last birthday) Manths Oays Hours WIDOWFD DIVORCED male Negro 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY Laborer Virginia

14. MOTHER'S MAIDEN NAME U.S.A 13 FATHER'S NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, na, ar unknown) (If yes give war ar dates of service) 218-07-7563 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. OEATH WAS CAUSED BY: anterio Sclerotic CArbia VASCULAT IMMEDIATE CAUSE (a) signed by DUF TO Canditians, if any, which gave rise ta immediate cause (a). DUE TO stating the underlying cause be retained by the haspital or attending O FUNERAL DIRECTOR: After this certificate has been as the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO CEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) far use CERTIFICATION NO 20a. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State) 20c, TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Not While at wark 21. I certify that (1) (this haspital) attended the deceased fram , ta 9 9 7 967 , 19 \_\_\_ , that (1) (we) last , 19 19 67, and that death accurred at 7:25 A.M. fram causes and an the date stated above. saw the deceased alive an 9-9 22a. SIGNATURE 22b. DATE SIGNED 9-9-67 MED. DIRECTOR ATTENDING M.D. be filed 22d. ADDRESS 22c. PHYSICIAN'S Paul G. Ensor M.D. Baltimore. Md. NAME (Type) directar, 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) Balto. 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR 25g. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66

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HEALTH DEPT.		PLACE OF DEATH o. COUNTY		100		MARYL	AND	2. USUAL RESIDENCE o. STATE		b. (O	JNTY			
ry delay is 2, and 3 to PM3. Page artment of		b. CITY OR TOWN ( write RURAL one	Carroll If outside corporate limit d give nearest town)	ts,	c. L	ENGTH OF STAY IN		c. CITY OR TOWN (1	land outside corpo	orote limits, write R	URAL ond gi	rroll ve neorest	town)	
P. Z.		Finksb d. NAME OF HOSPIT	urg AL OR INSTITUTION (If n	ot in hospitol,	give st	reet oddress)		Finksb d. STREET ADDRESS	urg			e. IS RESIDENCE ON A FARM?		
fer death. If of Give Pages 1, and with farm		Carrol NAME OF DECEASED	1 County G	eneral irst	Hos	<b>Spital</b> Middle		Finks	A. DATI	Maryland Mo	nth	Doy Year		
8. Give alang with the	S.	(Type or print)	6. COLOR OR RACE	RVIN 7. MARRIED	x	E. NEVER MARRIED		BOSLEY  B. DATE OF BIRTH	OF DEAT	9. AGE (In yeors last birthdoy)	IF UNDER		1967 IF UNDER 24 HRS. Hours   Min.	
s certificate shauld be executed within 24 haurs after death. If we, writing the ward "pending" in pencil in Item 18. Give Pages 1, farwarded to the Chief Medical Examiner's Office along with farm used as a burial-transit permit. File pages I and 2 with the State Deparaval, and in any event within 72 haurs after death.	100	Male USUAL OCCUPATION	White (Give kind of work done			DIVORCED BUSINESS OR		March 12, 1	te or foreign	75 yrs.	12. 0	ITIZEN OF		
thin 24 I miner's C pages I pages I		ng most of working FATHER'S NAME	ine, even in renired)		NUUSIK	1		Marylar  14. MOTHER'S MAIDER				OUNTRY?		
d within in pencil Examine File page	15.	Samuel WAS DECEASED EVE	DINITIC ADMED CODCECS	16.	. SOCIAI	L SECURITY NO.	17. 1	NFORMANT	ry Tau	Add	ress			
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shauld be e ne ward "per ia the Chief I burial-transit n any event v		PART I. DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE	(o) A 8			f g	astric cor	ntents	3			ET AND DEATH	
e shaul the war ta the burial- in any		Conditions, if ony	e couse (o), (	(b) <u>Ga</u>	str	o-intes	tin	al obstruc	ction					
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(AM) te the the day of aur age emale	MEDICAL	Hour o.r p.r	n. 19	While of wo	e rk	Not While ot work	foct	CE OF INJURY (Home, for ory, street, office bldg., et	tc.)		<u> </u>	ounty)	(Stote)	
MEDICAL EXAM blease execute the director. Page 4 etained for your DIRECTOR: Page to burial, cremo		21. I certifi death result	<b>y</b> that I took charg ted from: Natur			Accident,		ide 🔲 , Hamicio	de 🔲,	Undetermined r	uiry, nanner [	and	in my apinian	
Y MEDICA , please ex- al director. retained t		ACTUAL SIGNATURE	OPH	who	n	/		M.D. ASSISTANT M	EDICAL EXAM	IINER 🔲		2:	2. DATE SIGNED	
TO DEPUTY MEDICAL EXPRESSORY, please executive funeral director. Pag 5 may be retained for 10 FUNERAL DIRECTOR: Page 14 prior to burial, cr	22	EXAMINER'S NAME (Type)	Rusgell S.	Fisher	r <b>,</b> ,}	MAME OF CEMET	CDV 0.0	DEPUTY MED Address (Stre	eet, city, tow	n, or county)			9, 1967	
07 # 20 # # 20 # # 20 # # 20 # # 20 # # 20 # # 20 # # 20 # # 20 # # 20 # # 20 # # 20 # # 20	230	Burial (Specify	Sept. 1	2,67	9	leasant	Gro	1e	. 3	Boring,	Md.	(County)	(Stote)	
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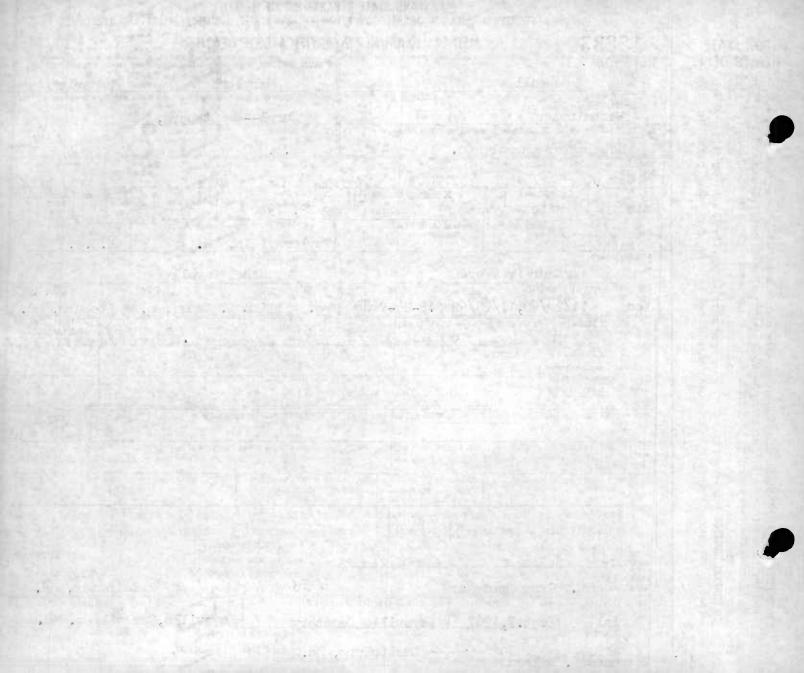
Come II - May land Manchester 3 Like Course mayor engther Kinson Home Inc Welle B Brodbeck Prope Frenche Water Jan 19 1903 to Howeverger Home Carrel Co. Maryland Hill Column abus . Section . Se 217-45-5803 Hellie Budhast - devased Hill at the hope it, 1967 mean outh forebery at Greenwount, fd. Alter - die Cineral ness dimensons .bw. .bw. .bushemile seen Leroma enlis - dealis

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12231 CERTIFICATE OF DEATH 12242 requires that the death certificate be executed within 24 hours after death physicion and completely filled in by the funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY a. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If autside corporate limits, write RURAL and give neorest tawn) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) tminster e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREEL ADDRESS ON A FARM? Koute 'AUnt YES NO 🔀 carbon NAME OF DATE Last Month Dov Year DECEASED OF DEATH 1967 Type or print SEX IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR NEVER MARRIED last birthday) Manths ond in any WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 10a, USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during mast of warking life, even if retired) pleose INDUSTRY COUNTRY 2 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT (Yes, no, or unknown) (If yes give wor ar dates of service 0 lestminst buriol, cremation, 18. CAUSE OF DEATH (Enter only one couse per line for to),
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN buriol-tronsit ONSET AND DEATH IMMEDIATE CAUSE (o) signed by DUE TO Canditians, if any, which gove rise to immediate cause (a), DUE TO stating the underlying cause hos been the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) CERTIFICATION NO YES TO FUNERAL DIRECTOR: After this certificate for 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Part II of item 18.) by the hospital (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or tawn) (County) (State) foctory, street, office bldg., etc.) Not While 21. I certify that ( (this hospital) oftended the deceased fram\_ 9-23-18-7.10 9-23 1967 that (we) last 19 67, and that death accurred at 5.22 PM, from causes and on the date stated above 9-23 saw the deceased alive on\_ 22a. SIGNATURE 22b. DATESIGNED director, poge 3 Should be filed v DIRECTOR 22d. ADDRESS 22c. PHYSICIAN S NAME (Type) Freen 23o. BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City ar Tawn) (County) (Stote) B REMOVAL (Specify) Sukesvi 2Sb. REGISTRAR'S SIGNATURE **EUNERAL DIRECTOR** VR A15 (4)

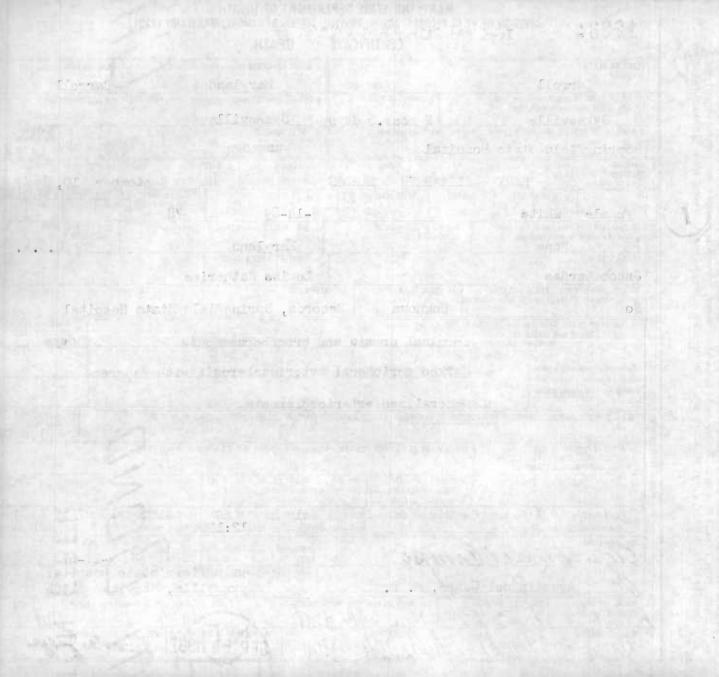
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FOR STATE		1440	S Trems	" MED	RCH AND RECORDS, 30 LOAL EXAMINER'S	CERTIFICATE	OF DEATH		12243	
HEALTH DEPT.		PLACE OF DEATH				2. USUAL RESIDENCE	(Where deceosed liv	ed, if institution:	Residence before odmission	on)
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This certificate should be executed within 24 icate, writing the ward "pending" in pencil in be farwarded to the Chief Medical Examiner's be used as a burial-transit permit. File bages in to burial, cremation, or removal, and in any			<b>EATH (</b> Enter only one co TH WAS CAUSED BY:	use per line for	(o), (b), ond (c).)				ONSET AND D	WEEN
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7	_	REMOVAL (Specify	-1 // /	167	M273/2	21/ (61	74 /9/	735	d11,10	14
VR A15ME (5)	24	FUNERAL DIRECTO	1 /		ADDRESS W		C'D BY REGISTRAR	2Sb. REGIS	RARIS SIGNATURE	1/021

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12233 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 12244 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Carroll Maryl and MARYLAND Frederick b. CITY OR TOWN (If outside carporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) write RURAL and give nearest town)
Westminster Rural -- Emmitsburg. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? hours in Item 18. Give Pages Westminster Carroll ate YES NO 16 after death. Office along, with NAME OF Middle 72 Last 4 DATE Month Doy DECEASED with the DEATH S. SEX 6. COLOR OR RACE NEVER MARRIED AGE (In years IF UNDER YEAR IF UNDER 24 HRS 7. MARRIED B. DATE OF BIRTH last birthday) Manths Haurs Doys Male White May 29, 1928 WIDOWED DIVORCED 24 hours event 0 pup 10o. USUAL OCCUPATION (Give kind of work dane during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT INDUSTRY COUNTRY? any Taylorsville. Md. Examiner's Painter pencil 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME within \_= Arthur Crawford Ethel Duvall and IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT be executed Address R. D. 2 Chief Medical permit. (Yes, no, ar unknown) (If yes give war or dates of s Yes 11/20/50, 11/ remaval, 20/52\*213-24-9688 Mrs. William L. Crawford, Emmitsburg, Md. 1B. CAUSE OF DEATH (Enter only one cause per ine for (o), (b), and (c).) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY: INSET AND DE 0 IMMEDIATE CAUSE (o) ward This certificate shauld crematian, DUF TO Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying cause writing last. OS burial, nsed PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? certificate. YES designated agent, priar ta 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) should PRIMARY ar CONTRIBUTING EXAMINER: CAUSE OF DEATH 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour o.m. factory, street, affice bldg., etc.) Nat While moy be retained for yaur FUNERAL DIRECTOR: Page While at work at wark 21. I certify that I took charge of the remains described above, held on Autopsy , Inspection X. ond in my opinion Inquiry deoth resulted from: Natural causes Accident Suicide TO DEPUTY DEUTY Homicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE L DEPUTY MEDICAL EXAMINER **EXAMINER'S** 5 moy ro FUNE Health 34 Green State of Sound Westminster, W. Glenn Speicher NAME (Type) 23o. BURIAL CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) Keysville, Carroll Co. Md. Kevsville Cemeterv Burial 24. FUNERAL DIRECTOR 2Sb. REGISTRAR'S SIGNATURE 2Sq. REC'D BY REGISTRAR VR ATSME (5) Emmitsburg. Md. DATESEP 6M 1/66 arence



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12245 Item #2d CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours ofter death 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) 1. PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Carroll Maryland after Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) popers. Pag hin 72 hours d. NAME OF MOSPITAL OR INSTITUTION (If not in haspital, give street address) 2 mons.6 days Sykesville = d. STREET ADDRESS e IS RESIDENCE hin 72 ON A FARM? filled unknown Springfield State Hospital YES NO X NAME OF First Middle Lost 4. DATE Month Doy Year ond completely DECEASED MARY (Type or print) ELIZABETH DARDAS September 19 67 DEATH 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED lost birthdoy) Months Doys Hours and a White 8-14-89 Female WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Caunty & Stote, or foreign country) 12. CITIZEN OF WHAT physicion ( en please INDUSTRY COUNTRY? Maryland None U.S.A 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Jacob Dardas Louise Catherine 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dotes of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Records, Springfield State Hospital Unknown 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN burial-tronsit ONSET AND DEATH PART I. DEATH WAS CAUSED BY Terminal uremia and bronchopneumonia IMMEDIATE CAUSE (o). DUE TO Conditions, if ony, which gove Marked peripheral arteriosclerosis with gangrene rise to immediate couse (a), DUE TO stoting the underlying couse lost. () Generalized arteriosclerosis 19. WAS AUTOPSY PERFORMED? hos PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO ATTENDING PHYSICIAN: 20o. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e, PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED (City or town) (County) (Stote) Hour o.m. Not While foctory, street, office bldg., etc.) of work 19.67 to September 1.09.67, that (We) las 21. I certify that (X (this haspital) attended the deceased fram July h be retained saw the deceased alive an\_ and that death accurred al 2:10AM, from causes and on the date stated above TO FUNERAL DIRECTOR: 22b. DATE SIGNED 220 SIGNATURE ATTENDING M.D. DIRECTOR PHYS 22d. ADDRESS Springfield State Hospital PHYSICIAN'S NAME (Type) Agustin del Sykesville, Maryland 2178h director, 23o. BURIAL CREMATION 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) 24., FUNERAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR VR A15 (4) 25M 1/67



1		MARYLAND STATE DE Division of STATISTICAL RESEARCH AND RECORDS, 30	EPARTMENT OF HEALTH  N PRESTON STREET RAITIMORE MARYLAND 212	201
FOR STATE		1000	CERTIFICATE OF DEATH	12248
HEALTH DERT		PLACE OF DEATH O. COUNTY  Carroll  MARYLAND	2. USUAL RESIDENCE (Where deceosed lived, if institution: Residen o. STATE b. COUNTY Ca:	rroll
If any delay is st. 1, 2, and 3 to form PM3. Page to Deportment of aurs after death.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Taneytown	c. CITY OR TOWN (If outside corporate limits, write RURAL and give Taneytown	06-1
Pages 1, 2 with farm		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  55 George Street	d. STREET ADDRESS 55 George Street	e. IS RESIDENCE ON A FARM? YES NO 🛣
a Give Page along with the State within 72 ho		NAME OF DECEASED (Type or print)  6. COLOR OR RACE  7. MARRIED  NEVER MARRIED  NEVER MARRIED	8. DATE OF BIRTH  4. DATE OF DEATH  9. AGE (In years LIF UNDER	Doy Year  Z 1967  1 YEAR   IF UNDER 24 HRS.
I haurs af Item 18. Office alo I.and 2 w		Female White WIDOWED DIVORCED	Feb. 2, 1924 (ast birthday) yrs. Months	Doys Hours Min.
		ing most of working life, even if retired)  None  None  None	Maryland U. 14. MOTHER'S MAIDEN NAME	UNTRY? S.A.
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e executed pending" in ef Medical E sit permit. F remaval, a	(1)	18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).	oyd C. Dern 55 George St., To	aney <b>bor</b> n, Md.
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exe ar. P d fo d fo gnat		21. I certify that I took chorge af the remoins described obove, he death resulted fram: Natural causes , Accident , Suic	cide, Homicide, Undetermined manner	and in my apinia
		ACTUAL SIGNATURE WHEN Speicher	CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER	22. DATE SIGNED
o DEPUTY necessary, p the funeral 5 may be r 0 FUNERAL Bealth or it	230	EXAMINER'S NAME (Type)  W. Glenn Spetcher  BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR	Address (Street, City, 1944), or ounty)	(County) M(Sote)
2 = 5 2 T	24	BURIAL (REMATION, PRINCIPLE COMMENTAL SPECIFIC PRINCIPLE COMMENTAL SPECIFIC PRINCIPLE COMMENTAL PRINCIPLE	250. RECOLET REGISTRAR 19626. REGISTRAR'S SI	1 Carrage
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH death 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY b. COUNTY CARROLL timore City MARYLAND hours affer b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b requires that the death certificate be executed within 24 hours lvr / mo 2 da Baltimore City Sykesville e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS .⊆ and campletely filled 33 York Court, Balto. 21218 NO TX Springfield State Hospital 3. NAME OF Middle 4. DATE Manth First Year DECEASED WALTER NMN FINNEY 67 19 DEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. SEX B. DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** remove crematian, ar remaval, and in any ev birthday) Haurs 08/20/67 Male White WIDOWED KX DIVORCED 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR COUNTRYS during most of warking life, even if retired) **INDUSTRY** Maryland, Churchville Cork &Seal Electrical EngineerCrown 13. FATHER'S NAME J 14. MOTHER'S MAIDEN NAME George/Finney Louisa Lyons Webster 17. INFORMANT 16. SOCIAL SECURITY NO. 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give wor ar dates af service) 220-07-3057 Springfield Hospital Records INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter anly ane cause per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: signed by the burial-transit p ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gove rise ta immediate cause (a), DUE TO for use as the t f Health priar tab stoting the underlying couse Page 4 may be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? CBS assoc. with senile brain disease with psychotic reaction NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, (City or town) (Caunty) (Stote) 20d. INJURY OCCURRED 20c. TIME OF INJURY Manth, Doy, Year foctory, street, affice bldg., etc.) at work 9/15/67 . 19\_\_\_, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased fram 5/13/66 . 19 19 , and that death accurred at 2:15 PM, fram causes and an the date stated above saw the deceased alive an 9/15/67 22b. DATE SIGNED 22o. SIGNATURE MED. DIRECTOR STAFF PHYS. 9/15/67 M.D. 22d. ADDRESS 22c. PHYSICIAN'S Springfield State Hospital NAME (Type) director, g 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) 23o. BURIAL, CREMATION, Burial (Specify) Churchville Presb Ch Chur ADDRESS 250, REC'D BY REGISTRAR Churchville 25b. REGISTRAK'S SIGNATURE 24. FUNERAL DIRECTOR Co Ba Road VR A15 (4) & Sons

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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## CERTIFICATE OF DEATH

12248

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ottending permit. The				R IN U.S. ARMED FORCES? (If yes give war or dates o	fservice	SOCIAL SECURITY N		NFORMANT			Ad	dress			
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or arrenaing icate has been for use os the Health prior to	2	ATION	PART II. OTHER SIG	GNIFICANT CONDITIONS CO	ONTRIBUTING	ah lu	RELATED TO	THE TERMINAL	DISEASE COND	ITION GIVE	EN IN PART 1(a)			WAS AUTO PERFORM ES	OPSY ED? NO
a table		CERT	200. ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY)	CAUSE OF DEATH	20b. DB	ESCRIBE HOW INJUR	Y OCCURRED.	(Enter nature o	af injury in Po	art I or Pai	rt II af item 1B.)				
rne nos r this ce detache te Dept.		MEDICAL	20c. TIME OF INJU Haur a.n p.n	10	20d. I While			CE OF INJURY ( ory, street, affic		20f.	(City or town)	(Co	ounty)	(	State)
Afte Afte J be e Sto			21. I certif	y that (I) (this has		ded the deceas	ed fram_	9/3		67,1	0 9/1				we) last
OR: oul		-		ceased alive an	1/11	19 6	Z, and tha	t déath acc	urred af	Jo Alv	A, fram cause				abave.
DIRECT DIRECT ge 3 sh led with			22a SIGNATURE	my 15	Leil	ee	/ M.I		le D	NED. PIRECTOR	STAFF PHYS.	D 226. D	DATE SION	-1/6	69
FUNERAL C rector, pog aguld be fil	1		22c. PHYSICIAN'S NAME (Type)	HARRY	DE	FIBEL	M.I	22d. AD	DRESS			/		/	
Specific directo	0	23a.	BURIAL, CREMATIO	N, 23b. DATE THE	REOF	23c. NAME OF (	4.4	4.4. 4		-	OCATION (City or		(Caunty	) (S	tate)
2 5 4	Y		REMOVAL (Specify)		7	Prospe	ect Hi	U Ceme			wson	Bal		Md	
VR A15 (4)	U	24.	FUNERAL DIRECTO			ADDRESS	MII		2Sa. REC'D	F P REGISTI	RAR 1967	REGISTRAR'S	SIGNATUR	Jus	400
25M 1/67			John Ru	and Sona		lowson,	1104		DATE	-1 ~		-		0	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours often death.

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	1		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MA	
	ਦ ਰਿਮਦੇਸ਼		12233 CERTIFICATE OF DEATH	249
1	24 hours after death. filled in by the funeral apers. Pages end-n 72 hours after death.	1.	a. STATE b. COUNTY	, 0
	the es	-	b. CITY OR TOWN (if outside corporate limits,   c. LENGTH OF STAY IN 1b   c. CITY OR TOWN (If outside corporate limits, write RURAL a	and give nearest town
	in by the s. Pages hours aft	V	b. CITY OR TOWN (if outside corporate limits, write RURAL awrite RURAL and give nearest town)  Northeader, Md. 10 Mo. Blue Rodge Summer	75 3
	ithin 24 hours etely filled in loon papers. Pwithin 72 hours	0-1	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENC ON A FARM?
		3.	NAME OF FIRST MIDDLE LAST 14 DATE MONTH	YES NO
	The law requires that the death certificate be executed within or attending physician.  or attending physician.  cate has been signed by the attending physician and completely use as the burial-transit permit. Then please reports about a salth prior to burial, cremation, or removal, and in any event with	3.	NAME OF DECEASED (Type or print)  A Middle  Last  4. DATE OF OF DEATH 9	Day Year 17 1967
	Level of the	5.	WARRIED NEVER MARRIED OF SALE OF SMILE	YEAR IF UNDER 24 HR
	executed w	17.	emole white WIDOWED DIVORCED Dec 10, 1880 56 yrs. Months	Days Hours Min.
	in in in	10 du	a. USUAL OCCUPATION (Give kind of work done   10b. KINO OF BUSINESS OR ring most of working life, even if retired)   12. CIT COL	TIZEN OF WHAT UNTRY?
	hysician please r	N	noneger of hevely Stre Blee Rody Summit Pa. 4	54
	icat phy n p val,	13	FATHER'S NAME 1 0 14. MOTHER'S MAIDEN NAME	1225
	The The		Jacob Jeslie Filz Henritta L'ellerger	
	h certifica tending ph iit. Then or removal	1! (Y	5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address es, by, or unknown) (If yes give war or dates of service)	
	e death co the attenc it permit. nation, or r	1,,	no (1905) Tena di cates di service) 219-54-1014 Ray C. 7 eta (nepheur) charmain	-, Pa.
	the dit		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN
	by by ansirem		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (Arme My o Cushtie)	ONSET AND DEATH
	thai sicis med al-tr al, o		4221 DUE TO $0.4$ $0.0$ $0.4$	
	sig sig ouri		conditions, If any, which ) ( I true our bottle ( or do lasule lessons	
	ng ng een he t		gave rise to Immediate cause (a), stating the DUE TO	
	endi endi is b is th		underlying cause last. (c)	
	atte atte b ha se a se a th b	NO.	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED?
	eal cat	SA		YES NO
	PHYSICIAN: The law requires that the hospital or attending physician. this certificate has been signed b detached for use as the burial-tran e Dept. of Health prior to burial, cre	CERTIFICATION	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF OEATH	
	Sich hos che che		(IF EITHER, NOTIFY MEDICAL EXAMINER)	
	this this De	MEDICAL	20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20e. PLACE OF INJURY (Home, farm, Hour a.m.   While Not While   Not While   Factory, street, office bidg., etc.)   (Coun	nty) (State)
	by ter ter tate	G W	p.m. 19 at work at work	
	OR ATTENDING I be retained by in DIRECTOR: After ge 3 should be old with the State		21. I certify that (I) (this hospital) attended the deceased from 11-24, 1966, to 9/17, 1967	Z, that (I) (we) las
-	Harrier Harrie		saw the deceased alive on $9/17/67$ 19, and that death occurred at $AM$ , from the causes and on the	
	R A B C C C C C C C C C C C C C C C C C C		22a. SIGNATURE ATTENDING MED. STAFF 22b. DA	TE SIGNED
	ly begage		M.D. PHYS. DIRECTOR PHYS.	
	SPITAL 4 may IERAL D tor, pag d be file		22c. PHYSICIAN'S NAME grype) 22d. ADORESS	1
	UNE 4	-	Loseph E. LSush MD HAMPS FEAD MAR	110MG
	TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deat Page 4 may be retained by the hospital or attending physician.  TO FUNERAL DIRECTOR: After this certificate has been signed by the at director, page 3 should be detached for use as the burial-transit pern should be filed with the State Dept. of Health prior to burial, cremation,	23	REMOVAL (Specify)	
		-01	Burial 9/19/67 Methodist, Fountaindale Fairfield #1, Adam	s Co. Pa.
		24	- 0 10017	en Judge
	VR AIS (4) 20M 1/65	14	Walter Heliove Waynesboro Pa. DATESEP 19 1961 floore	0
	,			

Surfat 9/19/67 Hetnodist, Tountaindale Feirfiell 11, Adens Co., Ed.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12250 12233 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission) o. STATE b. COUNTY MARYLAND Mont. Co. 15 c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) 2분 months Chevy Chase e. IS RESIDENCE ON A FARM? d. STREET ADDRESS NO [ Kirke St YES Yeor John atrick DEATH September Fitzgerald 9. AGE (In years lost birthdoy) 6. COLOR OR RACE NEVER MARRIED 8. DATE OF BIRTH IF UNDER 1 YEAR 7. MARRIED Months Dovs White WIDOWED DIVORCED March 11 15 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? None Washington D.C.
14. MOTHER'S MAIDEN NAME II.S. Clara Felton 17. INFORMANT 16. SOCIAL SECURITY NO. Springfield State Hosp, Sykesville Md None INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE (AUSE (a) Sub-acute bacterial endocarditis Waaks DUE TO DUE TO (c) Congenital heart disease-aortic stenosis vears 19. WAS AUTOPSY PERFORMED? Pneumonitis NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Port II of item 18.) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (Stote) (County) foctory, street, office bldg., etc.) 21. I certify that (1) (this haspital) attended the deceased fram July 11, 19 67, to Sept. 3, 19 67 that (1) (we) los saw the deceased alive an Sept. 3, 19 67, and that death accurred at 2-10 M, fram causes and an the date stated above 22b. DATE SIGNED

1967

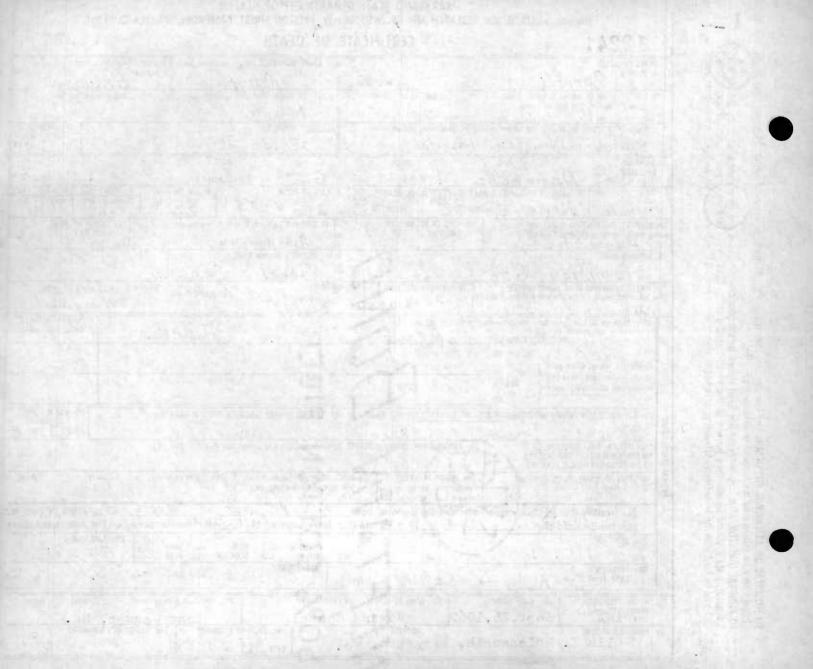
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death, o. COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL ond give negrest town)
Sykesville, .⊆ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) filled Springfield State Hosp. Sykesville Md NAME OF campletely DECEASED (Type or print) S. SEX male 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 13. FATHER'S NAME Bernard M. Fitzgerald 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY: Conditions, if ony, which gove rise to immediate couse (a). stoting the underlying couse certificate has been PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) CERTIFICATION 20o. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Dov. Year TO FUNERAL DIRECTOR: After be retained saw the deceased alive an Sept 3 220. SIGNATURE STAFF PHYS. DIRECTOR M.D. PHYS. 22c. PHYSICIAN'S O HOSPITAL Springfield State Hospital NAME (Type) Octavio A 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL CREMATION. 23b. DATE THEREOF 23d. LOCATION (City or Town) Wheaton, Md.

STRAR | 25b. REGISTRAR'S SIGNATURE 9/6/67 Gate of Heaven 250. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 Charles >

Jos. Gawler's Sons, Inc., Wash., D.C. DATE SEP

the militaricality among oil and be seemed in rotorio della contra di la cont The state of the state of the state of Sunfed: S/mysr Onto of Heaven ! Meaven, Mt. def. design down, late, holde, t. C. on S. S.

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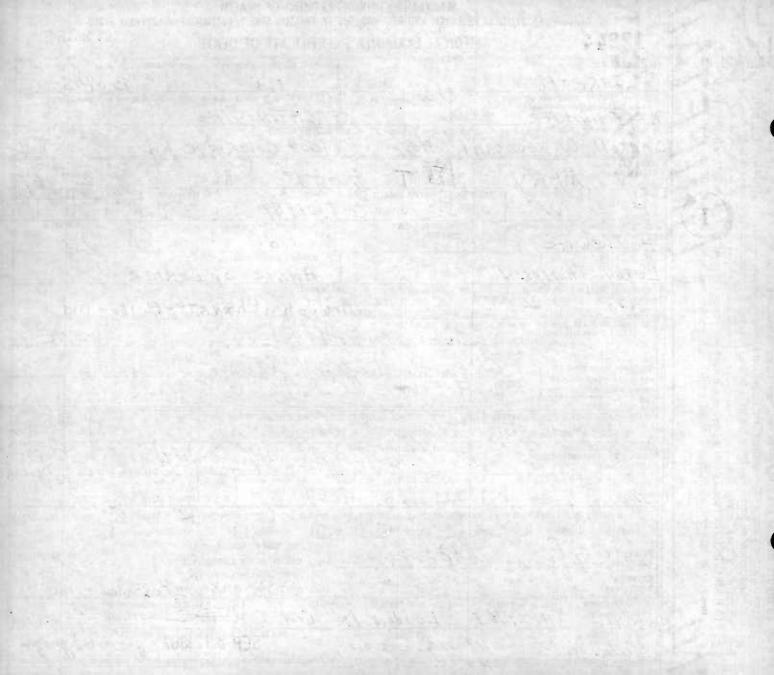
2	1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
		12242 CERTIFICATE OF DEATH 12253	
	te death.	1. PLACE OF DEATH  o. COUNTY  ARROLL  b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn)  2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)  o. STATE  MARYLAND  c. LENGTH OF STAY IN 1b  c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn)	
•	within 24 hours afty ely filled in by three bon papers. Pages within 72 hours aft	write RURAL and give nearest town)  WESTMINSTER  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)  d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?	
	be executed within 2 and campletely filled e remave carbon pap	3. NAME OF PIECE ASED (Type or print) EVA SUE HAHN Last 4. DATE Manth Day Year OF DEATH 9 14 1967	7
	be executed with and campletely to remave carbon in agreeant with	DIVORCED   JULY 15, 1894   last birthday)   Months Days Haurs M	
	ertificate be physician an nen please ra naval, and in	during most of working life, even if retired)  HOUSE-WIFF  13. FATHER'S NAME  CHARLES BARKS DALE  INDUSTRY  CHARLES BARKS DALE  PINKIE ROGERS	
	he death certif s attending phy permit. Then tian, ar remava	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war ar dotes of service)  214-01-0676 DUDLEY E, GREENHOLTZ 38 HOOK RD WEST MIRKSTER M	24
	physician. physician. signed by the burial-transit burial, cremat	18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).)  PART 1. DEATH WAS CAUSED BY:  (Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause lost.  (c)  1NTERVAL BETWEEN ONSET AND DEATH  (b)  ARTERIO SCLEROTIC HEART DISCLASE  (c)	
	: The or attente has use a alth pr	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY	
	c PHYSICIAN: the hospital ar this certificate detached far u ie Dept. af Healt	PERFORMED? YES NO  200. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  200. TIME OF INJURY Month, Day, Year Hour a.m.  10  PERFORMED? YES NO  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)  20c. TIME OF INJURY Month, Day, Year Hour a.m.  10  (Caunty) (State	i la
	IDING PHY A by the ho After this c be detach State Dept	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.  20d. INJURY OCCURRED While at wark at war	
•	OR ATTEN be retained DIRECTOR: ge 3 should led with the	saw the deceased alive on 9/4 1962, and that death occurred at 75 M, from couses and on the date stated ob  220. SIGNATURE  220. PHYSICIAN'S  NAME (Type)  221. PHYSICIAN'S  NAME (Type)	10 V
	TO HOSPITAL Page 4 may TO FUNERAL director, pages	230. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote)  BENOVAL (Specify) 9/18/67 EVERGREEN MEM. GARDEN'S FINKS BURG MD.	
	VR A15 (4) 20 M 1/60	24. FUNERAL DIRECTOR  ADDRESS  ADDRESS  250. RECID BY REGISTRAR SIGNATURE  250. REGISTRAR'S SIGNATURE  ADDRESS  DATE P 19 1967  ADDRESS  ADDRESS  ADDRESS  ADDRESS  ADDRESS  ADDRESS  ADDRESS  ADDRESS  DATE P 19 1967	

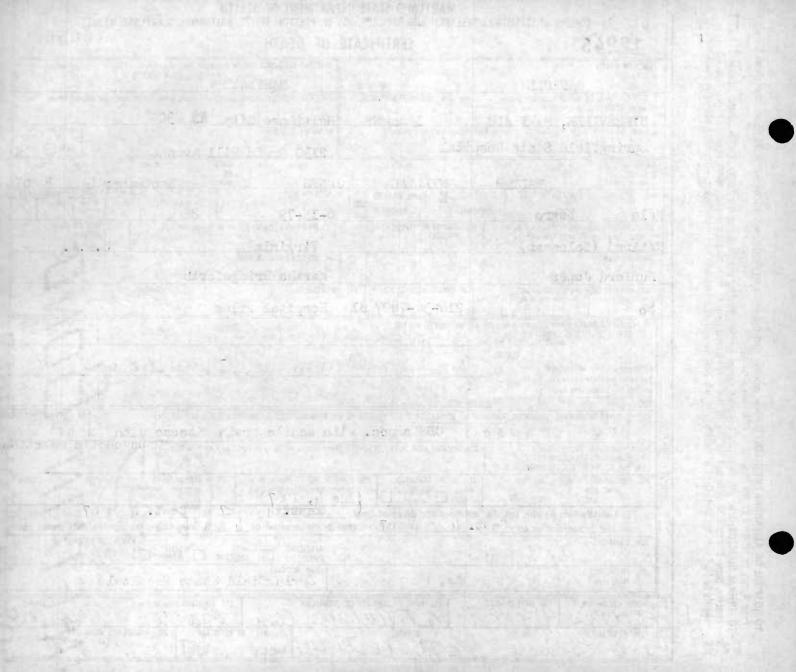
CALLY WILLIAM SALE SALES CHARLE OF THE PROPERTY AND THE PARTY OF THE PROPERTY. EVA SUE HIGHW FROM CE MATE TO SEE THE STATE TO SEE TO STATE TO SEE THE TO SEE TH SHATHAM VIEW TO THE STATE OF THE SECOND STATES CHARLES WARKSTONE PINNIE REFERS 214-01-0176 EVOLEY & CIEBONALES BENEZO GENEZO LEVELLE CARREST THEORETH WELD CHARLES ENVIOLENCE TO THE

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH 12254 1. PLACE OF DEATH 2. USUAL RESIDENCE (Whare deceased lived, if Institution, Residence before edmission) a. COUNTY b. COUNTY Carroll MARYLAND Maryland Carro b. CITY OR TOWN (if outside corporata limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL and give nearest town) writa RURAL end give nearest town New Windsor New Windsor vears d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d STREET ADDRESS . IS RESIDENCE ON A FARM? College YES NO TO Ave. death certificate be executed completel 3. NAME OF Middle 4. DATE Month Day Year DECEASED OF (Type or print) DEATH Mildred 9 19 67 Verna Hiteshew and cor 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED 5. SEX 9. AGE (In years | IF UNDER I YEAR IF UNDER 24 HRS. last birthday) Months Min. WIDOWED DIVORCED December 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired) office U.S.A. Johnstown, Pa. secretary 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Catherine Duncan Jacob 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unkown) | (Ifyes give war or dates of service) New Windsor Hiteshew 18. CAUSE OF DEATH Enter only one cause per line for (e), (b), end (c). INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Idenocarcinoma of the cervix and Uterus Conditions, if any, which gave rise to immediate cause DUE TO (a), stating the undarlying cause fast PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED, (Enter natura of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH MEDICAL 20c. TIME OF INJURY 20d. INJURY OCCURRED | 20e, PLACE OF INJURY (Home, farm, (County) (Steta) Month, Day, Yeer fectory, streat, office bldg., atc.) While Not While Hour a.m. el work et work 21. I certify that (I) (this hospital) attended the deceased from C 1966 to Sapa 10 ...., 1967, that (I) (we) last M, from the causes and on the date stated above. and that death occurred ItO saw the deceased alive 22b. DATE 22m. SIGNATURE SIGNED ATTENDING PHYS. DIRECTOR M.D. FUNERAL 22c. PHYSICIAN'S 22d. APDRESS director, p 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) 23a. BURIAL, CREMATION, | 23b. DATE THEREOF REMOVAL (Specify) Md. Carroll Pipe Creek Cemetery 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR'S SIGNATUR VR A15 15M 7

(former) mental a fresher THE LOSS WELL WITH MESTERS THE LEASE THE YEAR OF THE YEAR IN TO SEAL STATE OF THE SEAL S sould be good that a more read there But I was the water of the same of the sam By the second of THE PARTY OF THE PROPERTY OF THE PARTY OF TH

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12244 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) O. COUNTY CA o. STATE MARYLAND Department b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) pup write RURAL and give nearest town) CATONSVI TMINISTE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS hours ON A FARM? Coleridge GENERA Give Poges NAME OF 4. DATE Doy Year DECEASED Athe U (Type or print) DEATH S. SEX 7. MARRIED NEVER MARRIED B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS evern with Item 18. Months WIDOWED / Office 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Housewife Ξ Exominer's Onv 13. FATHER'S NAME pencil 14. MOTHER'S MAIDEN NAME 2 SPURRICR WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) removal. John ChRISTY-Balto-18. CAUSE OF DEATH (Enter only one couse per line tes (o), (b), and (c).) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY 0 IMMEDIATE CAUSE (o) should Word cremotian, DUE TO Conditions, if ony, which gove rise to immediate couse (a). stoting the underlying couse 0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMUNAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPS'
PERFORMED? 20o. EXTERNAL CAUSE WAS PRIMARY OF OF CONTRIBUTING ☐ CAUSE OF DEATH. prior 3 should 20c. TIME OF INJURY Month, Doy, Year Hame, form. facory, street office bldg., etc.) FUNERAL DIRECTOR: Poge of work of work L 21. I certify that I taak charge of the remains described above, held an Autopsy Inspection and in my apinian Accident X death resulted fram: Natural causes Suicide Hamicide Undetermined manner CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE he funeral TO DEPUTY pe DEPUTY MEDICAL EXAMINER **EXAMINER'S** Health Addres Greet with but organy buttom ore NAME (Type) 23o. BURIAL CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 0 REMOVAL (Specify) Cert 24. FUNERAL DIRECTOR 301 Tre VR A15ME





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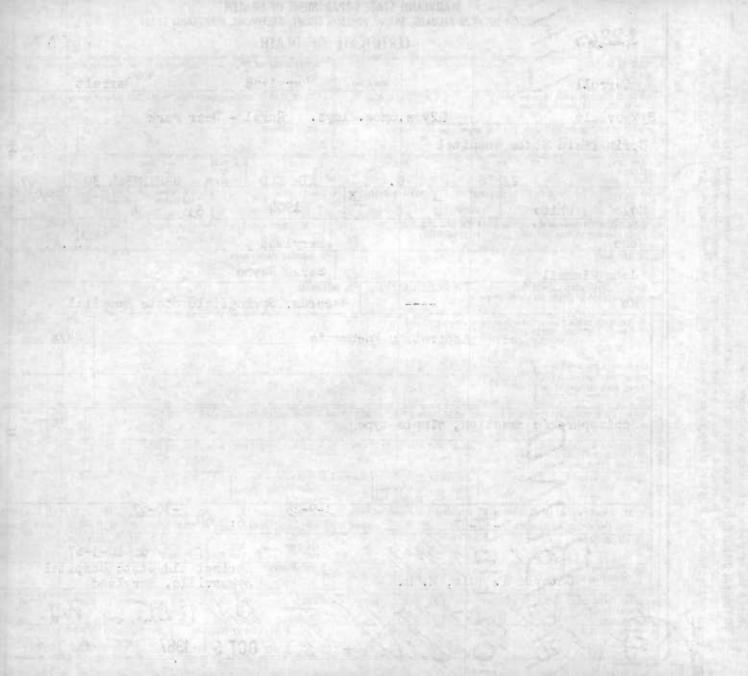
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12246 12257 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Maryland Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b 42vrs.6mos.2ldvs. Rural - Deer Park Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE d. STREET ADDRESS Springfield State Hospital YES NO DE 3 NAME OF Middle First Lost 4. DATE Month Year DECEASED (Type or print) JAMES D. KIMMELL DEATH 19 67 IF UNDER 1 YEAR IF UNDER 24 HRS SEX 6. COLOR OR RACE NEVER MARRIED 8. DATE OF BIRTH 7. MARRIED AGE (In years lost birthdoy) Months Hours 1904 White Male WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? None Maryland US 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Sarah Hayne John Kimmell 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO (Yes, no or unknown) (If yes give wor or dotes of service) Records, Springfield State Hospital INTERVAL BETWEEN DAYS 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY Aspiration Pneumonia IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUF TO stoting the underlying couse (c) WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) Schizophrenic reaction, simple type NO X 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) 20o. ACCIDENT WAS UNDERLYING [7] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour 'o.m. foctory, street, office bldg., etc.) Not While ot work 21. I certify that (1) (this haspital) attended the deceased fram. \_, that (I) (we) last 19\_\_\_\_, and that death occurred at 6:00 M, fram causes and an the date stated above. saw the deceased alive an 9-30-67 22b. DATE SIGNED 220. SIGNATURE **ATTENDING** 10-3-67 M.D. Springfield State Hospital 22c. PHYSICIAN'S 22d. ADDRESS Octavio A. Ruiz. Sykesville, Maryland 230. BURIAL, CREMATION, 23d/ LØCATION (City of Jown) 73b DATE THEREOF NAME OF CEMETERY OR GREMATORY (Stote) (County) MOVAL (Specify) 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 250 REC'D BY REGISTRAR 1967

The law requires that the death certificate be executed within **O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the hospital ar attending physician. this certificate has been OR ATTENDING PHYSICIAN: detached directar, page 3 shauld shauld be filed with the TO FUNERAL DIRECTOR: VR A15 (4) 25M 1/67



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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	1224	6		CERTIF	ICATE	OF DEATH					
1.	PLACE OF DEATH					2. USUAL RESIDENCE (	Where dece			e before	odmission)
	Carr	oll		MAR	YLAND	o. STATE Marvla	nd	b. cou	INIY		
	D. CITT OK TOYYN I	II OHINDS COLDOLOIS IIMI	s,	c. LENGTH OF STAY	IN 1b	c. CITY OR TOWN (If ou		rote limits, write RL	JRAL ond give	neorest t	own)
	Sykesvil	d give nearest town) Le, Maryla	nd	28 Day	5	3325 Dolf	ield	Ave. Bal	to. 15	_Md	3.4
	d. NAME OF HOSPIT	TAL OR INSTITUTION (If n	ot in hospitol, g	give street oddress)		d. STREET ADDRESS				e.	IS RESIDENCE ON A FARM?
		ield State	Hospit	al							S NO
3.	DECEASED 77	nnie Belle	irst Toolea	Middle		Lost	4. DATE OF DEAT		41	Doy	Year
5.		6. COLOR OR RACE	7. MARRIED	NEVER MARRIE	0 1 8	B. DATE OF BIRTH	DEAT	9. AGE (In years	IF UNDER 1	YEAR I	19 6 7 F UNDER 24 HRS.
	Female		WIDOWED	DIVORCE				last birthdoy)	Months		Hours Min.
100	USUAL OCCUPATION	Negro (Give kind of work done	10b. KI	ND OF BUSINESS OR		11. BIRTHPLACE (County	& Stote, or f	foreign country)		IZEN OF V	VHAT
duri	ng most of working Factory	life, even if retired)	IN	DUSTRY		77 6 4			COL	JNTRY?	
13.	FATHER'S NAME	MOTKET				14. MOTHER'S MAIDEN I	NAME				
	Robert	Maara			100						
15.	WAS DECEASED EVI	R IN U.S. ARMED FORCES?	16.	SOCIAL SECURITY NO.	17. 1	NFORMANT		Addı	ess		
(Ye		(If yes give wor or dotes	of service)								
	NO:	EATH (Enter only one co	use per line for	(a) (b) and (c))		ospital Rec	ords		1	INTED	VAL BETWEEN
	PART I. DEA	TH WAS CAUSED BY:	A	10, (0), 0110 (c),		3			- 13-43		AND DEATH
	17/X	IMMEDIATE CAUSE	(0)	Alton Arct	m	( ) ()					
	Conditions, if ony		(b) Q	20000	M	startation	1004	mains			
	rise to immedio	re couse (o),	10	covere con	- 1	Character .	VVV	man -			
	stoting the unde	erlying couse	(c) Ca	upon of	CO	Mrix.					
		IGNIFICANT CONDITIONS		TO DEATH BUT NOT RE		THE TERMINAL DISEASE CON	NDITION GIV	VEN IN PART I(a)		19 W	AS AUTOPSY
5	TAKI II. OITIEK 3	OMITICALLY CONDITIONS	CONTRIDUTINO	DOT NOT KE	OFILE TO T	THE TERMINAL DISEASE CO.	MOTITION OF	VEN IN TAKE 1(0)			AS AUTOPSY ERFORMED?
Z	20o. ACCIDENT WA	S LIMBERTAING T	I anh ne	SCRIBE HOW INTIDY O	CCLIDDED /	Enter noture of injury in	Part Las De	net II of item 10 )		YES	NO
CERTIFICATION	OR CONTRIBUTING	CAUSE OF DEATH	200. 00	SCRIBE HOW INJURY O	CCORRED. (	cine notice of injury in	ruii i oi ri	off it of them to.)			
		MEDICAL EXAMINER)  URY Manth, Doy, Year	204 11	JURY OCCURRED	200 PLAC	E OF INJURY (Home, farm	n, 20f.	(City or town)	(Cou	ntul	(Stote)
MEDICAL	Hour o.	m.	While	Not While		ory, street, office bldg., etc.)		(City of Town)	(00	11147	(31016)
	D		at worl		ſ	8 0.0	10.67	. 0 01.	10.4	7	(1) ( ) )
		fy that (I) (this ha		ded the deceased	fram	death accurred at		ta 9-21	, 19 <u>_</u> C	21, that	(I) (we) las
	22o. SIGNATURE	eceased alive an	=21	170(-,	unu mui	death accorded at	01967	m, irdii cdoses		TE SIGNED	
	ZZO. SIONATORE	111	00	Karrin	M.D	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	٦	1	
	22c. PHYSICIAN'S	Garania	N. C	Marino	m.b	22d. ADDRESS .	DIRECTOR	PHIS. L	1 9-2	4-67	
	NAME (Type		Ramo	3		Strugte	iela	State	toshit	61.	
230	. BURIAL, CREMATIO			23c. NAME OF CEM	ETERY OR (	CREMATORY	23d. 1	OCATION (City of To	own)	(County)	(Stote)
	REMOVAL (Specify		167			lem Tack	1	Mieter	Med		(=.5.5)
24	FUNERAL DIRECTO	)R allsh	4/	ADDRESS		250. REC'T	D BY REGIS		EGISTRAR'S SI	GNATURE	
1	La MI.	///////	-1 111	1/20 18.	0 01	Con 1 050	29/2	2046-1	10000000	. Man	100.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital ar attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral directar, page 3 should be detached far use as the burial-transit permit. Then please, jemave carbon papers. Pages search should be filed with the State Dept. at Health priar ta burial, crematian, or remaval, and it any event, within 72 haurs affer and

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The contract of the second of 188 Carlotte State State State 

1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
	12259
death. Uneral and 2 death.	1. PLACE OF DEATH a. CDUNTY  2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE  3. STATE  4. COUNTY  5. STATE  6. COUNTY  6. COUNTY  7. COUNTY  7. COUNTY  7. COUNTY  8. STATE
ter de la constant de	MARYLAND MAR
by the safe safe is af	b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  write RURAL and give nearest town)
hours d in by rs. Pa	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   d. STREET ADDRESS   e. IS RESIDENCE
fille pape of nin 72	ROUTE#1 ROUTE#1 ON A FARM?
OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after be retained by the hospital or attending physician.  INECTOR. After this certificate has been signed by the attending physician and completely filled in by the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 ad with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after	3. NAME OF DECEASED (Type or print) IAMALIAM RALPH MATHIAS LEESEDEATH SEPT 5 1967
com ove c	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH SEY 9. AGE (In years IF UNDER 1 YEAR   IF UNDER 1 YEAR
exec exec	DIVORCED DEC. D. 1707 L9 yrs.
sicial sicial and i	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  10b. KIND OF BUSINESS OR INDUSTRY  11b. BIRTHPLACE (County & State, or foreign country)  12. CITIZEN OF WHAT  CARROLL MARYAND  11c. CITIZEN OF WHAT  CARROLL MARYAND  CA
ificati g phy en pl oval,	13. FATHER'S NAME WILLPAM DANJELKING LEESE CECELIA I. MATHIAS.
certing unding rem	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANTO W. R. LE Eddes (Yes, no., or unknown) (If yes give war or dates of service)
the attending physician t permit. Then please ation, or removal, and in	100 - 219-01-188. POUTEHI WESTMINSTER
ires that the deat physician. n signed by the at burial-transit pern burial, cremation,	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) GASTROINTESTINAL DISEASE ONSET AND DEATH  ONSET AND DEATH  ON THE CAUSE (a) CAUSE (b)  ON THE CAUSE (C)  ON THE CAUSE (C)
that siclar sned al-tra al, cr	573X
z phy z phy n sig buri	Conditions, if any, which gave rise to immediate (b) HEPATOCEUUCAIC VISEITSE TO TEHIL
nding nding s bee	cause (a), stating the DUE TO underlying cause last. (c)
e faw atte e has se as th pr	
It The all or inficate for un. Health	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  19. WAS AUTOPSY PERFORMED? YES NO OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20a. ACCIDENT WAS UNDERLYING COURSED. (Enter nature of Injury In Part I or Part II of Item 18.) (If EITHER, NOTIFY MEDICAL EXAMINER)
PHYSICIAN: The law requires that the the hospital or attending physician. this certificate has been signed by detached for use as the burial-transice Dept. of Health prior to burial, crem	
PHYS the I r this detacted	20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20f. (City or town) (County) (State)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   20g. PLACE OF INJURY (Home, farm, factory, st
DING PH ed by th After ti id be de e State	p.m. 19   at work   at work   21.   certify that ( ) (this hospital) attended the deceased from AUGUSI, 1957, to SEPI, 1967, that ( ) (we) last
OR ATTENDII be retained IRECTOR: A ge 3 should sed with the S	saw the deceased alive on \$2.77 5 19 6 7, and that death occurred at 25 M, from the causes and on the date stated above.
OR A DIREC Se 3 Se 3 ed wi	22a. SIGNATURE  Daviel D Welliver M.D. ATTENDING MED. STAFF 22b. DATE SIGNED  PHYS. DIRECTOR PHYS. DATE SIGNED
TO HOSPITAL OR ATTENDI Page 4 may be retained TO FUNERAL OIRECTOR: A director, page 3 should should be filed with the	22c. PHYSICIAN'S 22d. ADDRESS 2
TO HOSPITAL Page 4 may O FUNERAL director, pa	23a. BURIAL, CREMATION, 23b. DATE THEREOF   23c. NAME OF CEMETERY OR CREMATORY   23d. LOCATION (City, town or county) (State)
5 5 P	BUNGAL (Specify) SEPT, 8 1967 BACHMANS CEMETERY NEAR NESTHINSTER, HE
VR A15 (4)	24. EUNERAL DIRECTOR ADDRESS 252. REGISTRAR 25b. REGISTRAR'S SIGNATURE
15M 4-64	James & Suffell Jules THINSTER, MOSTE SEP 7 1967 yourses Jusque

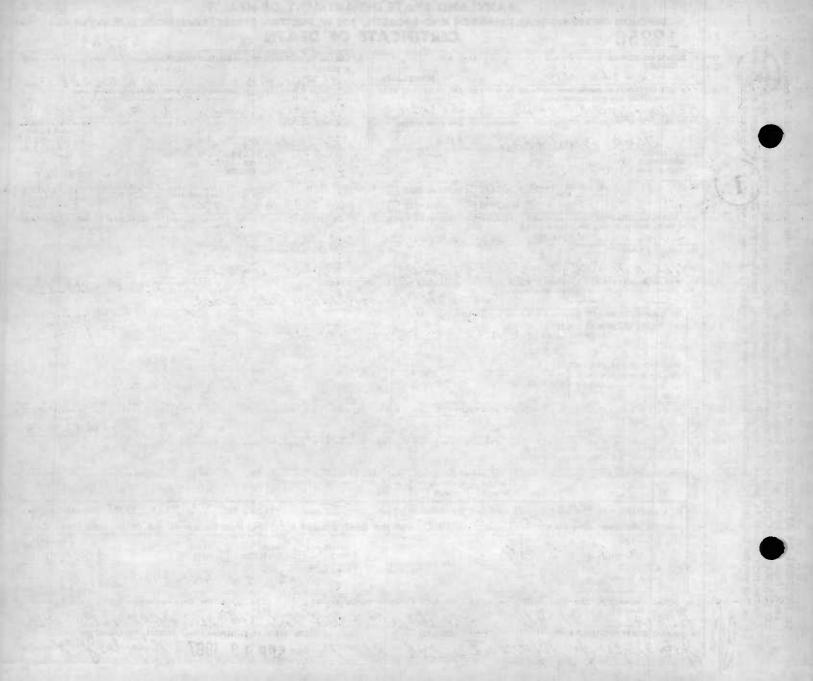
ACCEPTATION TO THE PARTY OF TH E THE SHIP THEN SECRETARY WERE LESSEN TO THE 

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

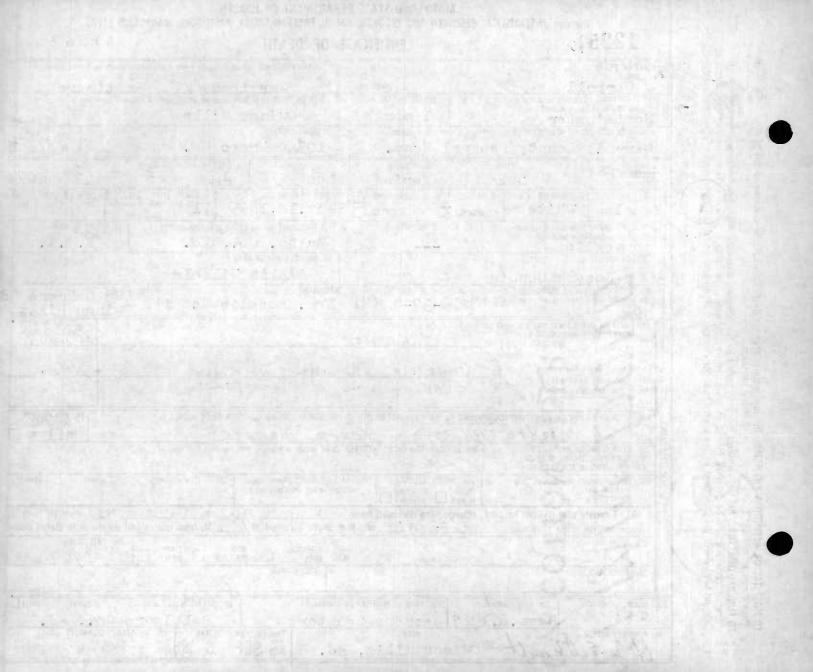
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4- 10 M		CERTIFICA	TE OF DEATH	
1. PLACE OF DE o. COUNTY	ATH		2. USUAL RESIDENCE (Where deceosed lived, if institution	n: Residence before odmissian)
Carro	11	MARYLAND	Maryland City	
b. CITY OR TO	WN (If outside carporate limit L and give nearest tawn)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If autside carporote limits, write RUR/	AL and give nearest tawn)
Rura	Sykesville	lyr 8 mo 9 c	Baltimore	30-4
d. NAME OF H	OSPITAL OR INSTITUTION (If no	at in hospitol, give street address)	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
Sprin	gfield State	Hospital	516 W. Mulberry St.	YES NO 5
3. NAME OF	Fi	irst Middle	Last 4. DATE Manth	Day Year
DECEASED (Type or print	JAN	MES B. LEFFERS	OF DEATH Septem	mber 19 1967
SEXMale	6. COLOR OR RACE	7. MARRIED NEVER MARRIED	8 DATE OF BIRTH 9. AGE (In years	Manths Doys Haurs Min.
Maxie	White	WIDOWED DIVORCED 🔀	11-07-1897 (ast birthday) 69 yrs.	multilis Doys Hours Mill.
10a. USUAL OCCUP	ATION (Give kind of work done rking life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (Caunty & State, or fareign cauntry)	12. CITIZEN OF WHAT COUNTRY?
_ Painte	2°	INDUSIK7	Florida	USA
13. FATHER'S NA			14. MOTHER'S MAIDEN NAME	
James	Leffers		Mary Johnson	
15. WAS DECEAS	D EVER IN U.S. ARMED FORCES?	of service) 16. SOCIAL SECURITY NO. 11	7. INFORMANT Addres	5
No.	D EVER IN U.S. ARMED FORCES? wn) (If yes give war ar dates o	220-05-8556 F	ecords, Springfield State	Hospital
18 CAUSE	OF DEATH (Enter only one cou	use per line for (o), (b), and (c).)		INTERVAL BETWEEN
PARI	DEATH WAS CAUSED BY: IMMEDIATE CAUSE	(a) Arteriosclerotic	cardiovascular disease	ONSET AND DEATH
420	DUE			
Conditions,	fony, which gove ) ediate cause (a),	(b) Generalized arter	riosclerosis	
stating the	underlying cause DUE	ТО		A CONTRACTOR OF THE PARTY
last.	2.	(c)		
PART II. OTH			O THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED?
Far a		mary tuberculosis,		YES NO
	T WAS UNDERLYING ☐ ITING ☐ CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRI	D. (Enter nature af injury in Part I ar Part II af item 18.)	
(IF EITHER, N	OTIFY MEDICAL EXAMINER)			
20c. TIME C	F INJURY Manth, Day, Year ir`a.m.		PLACE OF INJURY (Home, farm, 20f. (City or tawn) actory, street, affice bldg., etc.)	(County) (State)
	_p.m. 19	at wark 🔲 at wark		
21. 1	ertify that (x) (this has	pital) ottended the deceased from	1-10- , 1966 , to 9-19. nat death accurred at 1:10PM, fram causes a	, 1967 , that 10 (we) I
		<del>y-1y-</del> 19 <u>07</u> , and t	nat death accurred at 12: 10PM, fram causes a	
22o. SIGNA		Cel Campo.	ATTENDING MED. STAFF	22b. DATE SIGNED 9-19-67
22c. PHYSIC	2 9	cee campe.	M.D. PHYS. DIRECTOR PHYS. A	
NAME	+/h	del Campo, M. D.	22d. ADDRESS Springfield Sta Sykesville, Mar	te Hospital
230 ORTIRIAL CRI				
230 BURIAL, CRE REMOVAL (S	cify) 9-24	1 10 11 1	redom Sykesvill	(County) M (Signe)
N 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	P 121	U /   / V / / / / / / / / / / / / / / / /	THURS I JUNESVIII	C. /11///
24, FUNERAL DI	RECTOR	ADDRESS	25a. RECD BY REGISTRAR QC 25b. REG	ISTRAR'S SIGNATURE

A STREET AND A SECOND OF THE PROPERTY OF THE P 



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12251 12262 CERTIFICATE OF DEATH death. death eral 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND Maryland Baltimore The law requires that the death certificate be executed within 24 haurs after c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b 1 month Owings Mills Westminster d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENC the attending physician and campletely filled in sit permit. Then please reprave co(bon papers. ON A FARM? 105 Oakmere Rd. Carroll County General Hosp. YES NO X 3. NAME OF Middle Lost 4 DATE Manth Year DECEASED Lula Marie Long DEATH (Type or print) IF UNDER 1 YEAR 1 IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years - dast birthdoy) Months Sept.10,1895 Haurs White Female WIDOWED K DIVORCED 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife COUNTRY ? . A. INDUSTRY Balto. Co.. Md. 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Amelaa Wilhelm Joseph Corbin 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Oakmer e (Yes, na, ar unknawn) (If yes give war ar dates af service) 218-32-0256D Mrs. Rosalie Caudill 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit URFMIR IMMEDIATE CAUSE (a). signed by DUF TO CHRONIC RENAL DISEASE Conditions, if ony, which gove rise to immediate cause (a), (ARTERIOLAR NEPHROSCLEROSIS DUE TO stating the underlying couse TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been as the 19. WAS AUTOPS)
PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) POTHY ROID NO T YES Por 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Dov. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Haur o.m. factory, street, office bldg., etc.) Not While 21. I certify that (I) (this haspital) attended the deceased fram\_ 2/2 , 1967, to 9/3 , 1967, that (I) (we) last 9/2 1967, and that death accurred at 1 32 M, from causes and on the date stated above. saw the deceased alive on 220\_SIGNATURE 22b. DATE SIGNED ATTENDING M.D. DIRECTOR 22d. ADDRESS 224. PHYSICIAN'S NAME (Type) directar, should 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL CREMATION. (County) (State) REMOVAL (Specify) Sept.6,1967 Jessops Ceme tery Baltimore Co., Md. 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2Sa. REC'D BY REGISTRAR Milanely & DATE SEP 1967 Owings Mills, Md. 20 M 1/66



uneral 1 and 2 ve carbon papers. Pages 1 and 2 event, within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours Page 4 may be retained by the hospital or attending physician.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 12252 CERTIFICATE OF DEATH

a. COU				a. STATE		lived, If institution: b. COUNTY	Residence before	admission)
	arroll OR TOWN (if outside corporate te RURAL and give nearest town	limits, c. LENGTH	MARYLAND I OF STAY IN 1b	c. CITY OR TOWN (I	land f outside corporate		and give near	est town)
	esville. Md. F		ears street address)	Sykesy d. STREET ADDRESS	ille, Mo	1.	e. IS RE	SIDENCE
	Lee Lane			Lee L	ane:		YES	FARM?
3. NAME ( DECEAS (Type o		t Mi	lddle	Lynch	4. DATE OF DEATH	Month		ear
5. SEX		MARRIED NEVER	MARRIED   8	B. DATE OF BIRTH	10 100	11		67 ER 24 HRS.
Male	White	WIDOWED T	DIVORCED	5-17-03	64	birthday) Months	Days Hours	s Min.
during mos	OCCUPATION (Give kind of work do t of working life, even if retired)	State 0:		11. BIRTHPLACE (C			OUNTRY?	AT .
13. FATHE	R'S NAME	Duale U.	L. PIUI	14. MOTHER'S MAI		l U	S.A.	
Hov	ward Lynch		1000	Alice W	ebster			
15. WAS DE (Yes, no, or	CEASED EVER IN U.S. ARMED FOR unkown) (If yes give war or dates of s	CES?   16. SOCIAL SECU	URITYNO. 17.	INFORMANT		Address		
No		218-18-	-3.948 M	rs. Mary	Lynch-Sy	kesville	. Md.	
	AUSE OF DEATH [Enter only one		b), and (c).]				INTERVAL B	ETWEEN
( P)	ART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (	ongesti	ve Hear	t Failure				onth
44	DUE TO							
	ions, If any, which ) (t	Cardiomeg	aly				same	- 1
cause	(a), stating the DUE To	Myocardit					same	
PART II  2Da. AC  OR COM (IF EIT	OTHER SIGNIFICANT CONDITION	S CONTRIBUTING TO DEA	TH BUT NOT RELA	TED TO THE TERMINAL	DISEASE CONDITIO	N GIVEN IN PART 1(a)		NO X
2Da. AC OR COM (IF EIT	CCIDENT WAS UNDERLYING DEATH TRIBUTING DEAUSE OF DEATH HER, NOTIFY MEDICAL EXAMINE	20b. DESCRIBE HO	OW INJURY OCCU	RRED. (Enter nature o	f injury in Part I o	r Part II of Item 18	3.)	(20)
	IME OF INJURY Month, Day, Ye dour a.m. p.m. 19	ar 20d. INJURY OCCU While Not What work at work	ile factor	E OF INJURY (Home, f. y, street, office bldg., e	arm, 2Df. (City o	or town) (Co	unty)	(State)
	I certify that (I) (this hospit			ul 6 , 1	62 to Se	ot 11, 19	2, that (1)	(we) last
	the deceased alive on Se	pt 5 19	67, and that	death occurred at	:304A from th			d above.
	Sau P	andmo	Per M.D.	ATTENDING PHYS.		TAFE	t 11, ]	1967
22c.	PHYSICIAN'S NAME (Type)	- W D		22d. ADDRESS			24.2	
	Bant Okutin		AF OF OFMETTER			cesville.		
REMO	AL, CREMATION, 23b. DATE THE	and the second s	ME OF CEMETERY	Cemetery		N (City, town or co		State)
	RAL DIRECTOR	A ADDE				esville	'S SIGNATURE	
KI	Mr III Xaisht	Shiliniell	MA	DATE	FL 18 18	57 REGISTRAR	res Jus	ye

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	selected soft	Popul Landi	
the 'allies	Mes. Mery Canalistyne	HUST-BY-SIX	
	and the second second		
BERT		wispandinship and the con-	
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

19964

1.		.4400	CERTIFICATE OF DEATH	0 2
. Pages I and Liours after death.		LACE OF DEATH COUNTY Carroll	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence of STATE b. COUNTY Maryland Balti	before admission)
oppers. Pages I		CITY OR TOWN (If autside carparate li- write RURAL and give nearest town) Sykesville	imits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give LOmos.18dys. Baltimore	nearest tawn)
12		. NAME OF HOSPITAL OR INSTITUTION (II Springfield State	1 100 0 2 1 01	e. IS RESIDENCE ON A FARM? YES NO 10
)	3.	AME OF	First Middle Lost 4. DATE Month RED (NMN) MANNING DEATH SEPTEMBE	Day Year
	S.		7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years lost birthday) WIDOWED Sep DIVORCED 6-8-16 51 Yrs.	
	duri	USUAL OCCUPATION (Give kind of work do g most af warking life, even if retired) Laborer	one 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITI COL	ZEN OF WHAT
		FATHER'S NAME  John Manning	(1st name unk.) Paint	
	(Ye	WAS DECEASED EVER IN U.S. ARMED FORCE , no, ar unknawn) (If yes give war ar dat Unk	ES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Records, Springfield State Hospi	tal
		1B. CAUSE OF DEATH (Enter only one PART I. DEATH WAS CAUSED BY: IMMEDIATE CAU	USE (o) Status epilepticus	INTERVAL BETWEEN ONSET AND DEATH Days
		Canditians, if any, which gave	(b) Cerebrovascular accident  OUE TO	Days
2	ATION		(c)	19. WAS AUTOPSY PERFORMED? YES NO
	L CERTIFICATION	20g. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II of item 18.)	
	MEDICAL	p.ire.	19 While Not While at work factory, street, affice bldg., etc.)	nty) (State)
		21. I certify that (I) (this h saw the deceased alive an	naspital) attended the deceosed fram $10-25-66$ , 19 to $9-13-67$ , 19 $9-13-67$ , 19 $19-13-67$ , and that death occurred at $2:45$ M. From causes and an the	e date stated abov
154		22a. SIGNATURE	A COURS M.D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. 3 9-1	TE SIGNED 3-67
-1			o A. Ruiz, M. D. 22d. ADDRESS Springfield State Hos Sykesville, Maryland	pital
should be filed		BURTAL, CREMATION, 23b. DATE REMOVAL (Specify) 9-18	-67 Max M. (Inalone March) BALT MORT	(State)
(4) (h)	24	FUNERAL DIRECTOR	James Jamess 250, RECU BY REGISTRAR 250, REGISTRAR'S ST DATE P 19 1967	GNATURE

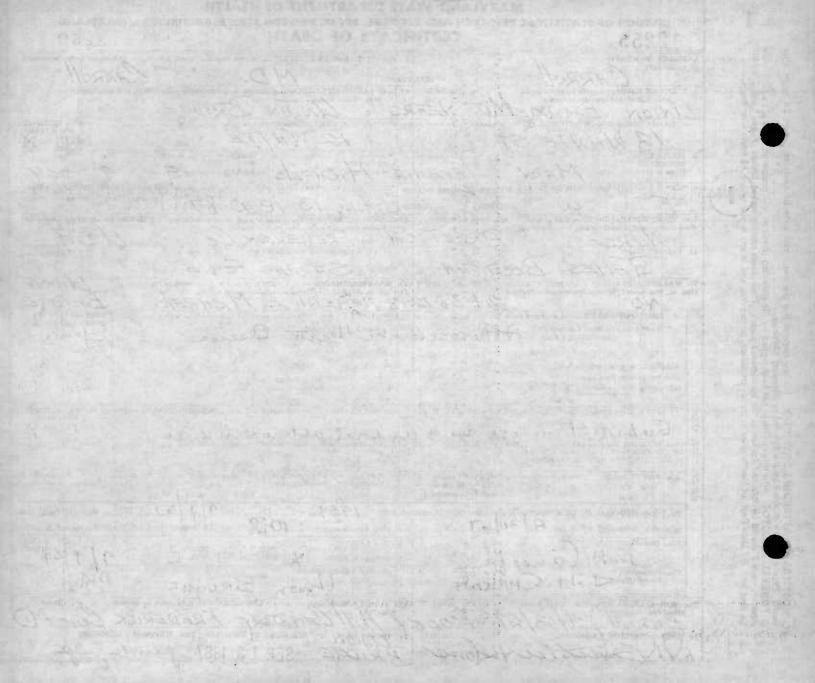
12254 0.C-6-cefet (. se desc del) 146 (V Z = 11 + 14.15 The State of the S SEP 18 SET TELESCOPE VILLE

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12265 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12254 FOR STATE HEALTH DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) ay is 3 to Page o. COUNTY o. STATE b. COUNTY MARYLAND Carroll Maryland delay and 3 1 the State Department b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carporate limits, write RURAL and give negrest town) PM3. Westminster Westminster e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS farm Rd. #1 Westminster, Ma in Item 18. Give Pages NO Rd. #1 Westminster, Md. YES 24 haurs after death. ward "pending" in pencil in Item 18. Give Pag the Chief Medical Examiner's Office along with NAME OF Middle 4. DATE OF Doy Year DECEASED (Type or print) DEATH SAMILET MELVILLE 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH lost birthdoy) Months Dovs Hours eath. WIDOWED DIVORCED land 2-YTS YES. Male White 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? within 72 hours after Unk Maryland pages U.S.A This certificate shauld be executed within 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Harry Melville Clark 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yes, no, or unknown) (If yes give wor or dotes of service) 217-12-9230 6513 Harrord Rd. Mrs Herman Mennerick 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY in any event Arteriosclerotic Cardiovascular Disease IMMEDIATE CAUSE (o) icate, writing the ward be farwarded to the Ch DUF TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse 0 and lost. OS 19. WAS AUTOPSY PERFORMED? remayal, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) CERTIFICATION the certificate, NO pe 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 3 shauld should PRIMARY Or CONTRIBUTING crematian, ar **EXAMINER:** CAUSE OF DEATH. MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While may be retained far yaur FUNERAL DIRECTOR: Page ot wark of work please execute 21. I certify that I taak charge of the remains described above, held an Autopsy Inspection X Inquiry [ ], and in my opinion death resulted fram: Natural causes (X), Accident ( Undetermined manner Suicide Homicide CHIEF MEDICAL EXAMINER Health prior to ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE M.D. DEPUTY MEDICAL EXAMINER **EXAMINER'S** Russell S. Fisher, M.D. NAME (Type) Address (Street, city, town, or county) Sept. 27, 1967 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23d. LOCATION (City or Town) (County) Burial (Specify) Sep. 29, 1967 Balto. Nat'l Cemetery Baltimore, Maryland
GISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 25o. REC'D BY REGISTRAR VR A15ME \$5 Villandes

MARYLAND STATE DEPARTMENT OF HEALTH

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DIVISION OF STATISTICAL RESEARCH AND RECORDS. RESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 12266 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution, Residence before edmission) a. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) write RURAL and give searest town) . IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION if not in hospitel, give street eddress ON A FARM? YES NO 3. NAME OF Middle 4. DATE Month DECEASED OF DEATH (Type or print) 196 withi 6. COLOR OR RACE 7. MARRIED THEYER MARRIED IF UNDER 24 HRS. 5. SEX 9. AGE (In years IF UNDER 1 YEAR pirthday) physician and Months Deys Hours WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work 10b, KIND OF BUSINESS OR INDUSTRY | 11. 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME please 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMAN (Yes, no, or unknown) | (If yes give wer or detes of service) INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if any, which (b) geve rise to immediate cause DUE TO (e), steting the underlying PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPSY PERFORMED? NO X Enromtosis due to cerebral 2De. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of item 18. OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (Stete) fectory, street, office bldg., etc.) While Not While Hour a.m. et work | et work p.m. 21. I certify that (I) (this hospital) attended the deceased from 1959 19 10... (a. /...., 19 ....., that (1) (we) last , from the causes and on the date stated above. saw the deceased alive on.... 22b. DATE 220. SIGNATURE SIGNED ATTENDING. STAFF DIRECTOR PHYS. PHYS. M.D. FUNERAL 22c. PHYSICIAN'S 22d ADDRESS 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Stete) 23a, BURIAL, CREMATION, | 23b. DATE THEREOF 25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE BUNERAL DIRECTOR'S SIGNATURE ADDRESS LNION A1S 15M 7-62



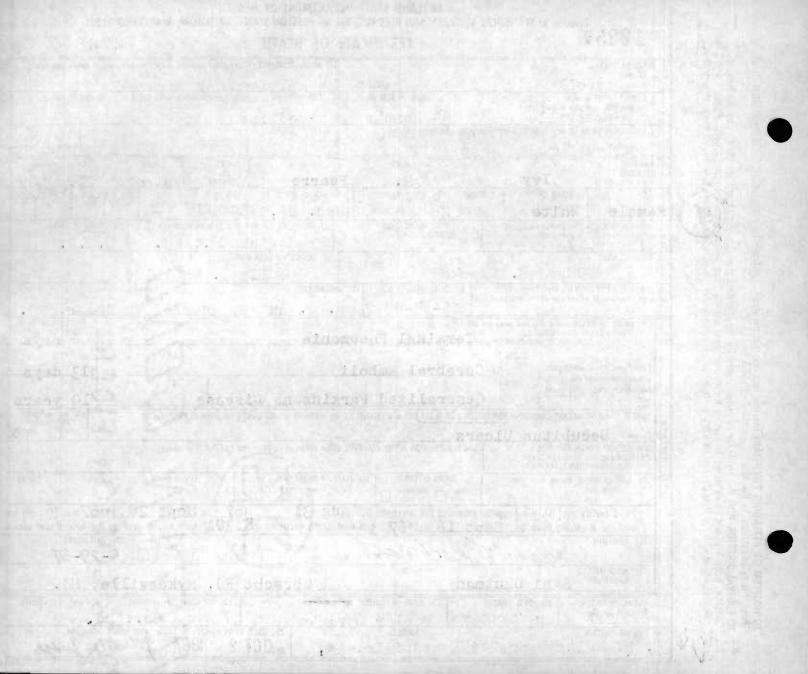
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) PLACE OF DEATH a. COUNTY Carroll a. STATEMARYLAND b. COUNTY SECONO after MARYLANO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b sician and completely filled in by lease remove carbon papers. Pag and in arty event, within 72 hours write RURAL and give nearest town 24 hours BALTIMORE CITY SYKESVILLE filled in I d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE d. STREET AOORESS ON A FARM? SPRINGFIELD STATE HOSPITAL 1518 Aisquith St. YES NO C executed within 3. NAME OF Middie Last DATE Month Oay Year First OECEASED OF DEATH FRANCIS 67 MORAN JR. 0. SEPT. 19 (Type or print) AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. | last birthday) | Months | Days | Hours | Min. 5. SEX 8. OATE OF BIRTH 9. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED male August 5. 1906. WIDOWED DIVORCED 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) 10a. USUAL OCCUPATION (Give kind of work done) 10b, KIND OF BUSINESS OR attending physician rmit. Then please COUNTRY? death certificate be during most of working life, even if retired) INDUSTRY II.S.A none Baltimore City .Md. none Then ple removal, a 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME FRANCIS O. MORAN CATHERINE 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address certificate has been signed by the attent hed for use as the burial-transit permit. t. of Health prior to burial, cremation, or r (Yes, no, or unkown) (If yes give war or dates of service) none MR. ARTHUR MARTIN 1506 AisquithSt. Balb INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] that the PART I. OEATH WAS CAUSED BY: OR ATTENDING PHYSICIAN: The law requires that the retained by the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which (b) gave rise to immediate as the prior to DUE TO vears cause (a), stating the underlying cause last. PARTIL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY CERTIFICATION for use PERFORMEO' disorder with psychotic reaction. hereditary), severe. With convulsive YES NO X (familial or 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) 20a, ACCIDENT WAS UNDERLYING age 4 may be retained by this certing FUNERAL DIRECTOR, After this certing and the detached for the property of the property o OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (County) (State) 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) 20c. TIME OF INJURY Month, Oay, Year factory, street, office bldg., etc.) Hour a.m. Not While at work at work 21. I certify that (I) (this hospital) attended the deceased from M, from the causes and on the date stated above. and that death occurred at saw the deceased alive on 19 22a. SIGNATURE ATTENDING DIRECTOR PHYS. M.D. PHYS. Page 4 may PHYSIC AN'S 22d. AOORESS director, p NAME (Type) NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State 23a. BURIAL, CREMATION, 23b. DATE THEREOF BEMOVAL (Specify) 0 New Cathedral Cemetery Baltimore. 25b. REGISTRAR'S SIGNATURE **ADORESS** 25a. REC'O BY REGISTRAR 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 VR A15 (4) 15M 4-64

STANCESTA JETS AS ENGLISHED IN grade Covernation manifectures Cardio verente distribuse atomat Larbeits well . You've Refreite gr deltimore, Hd. Lactaird J. Bulk. Tro. Bulto. Md. 2021

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12257 CERTIFICATE OF DEATH 12268 PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and campletely filled in by the funeral rowe carban papers. Pages 1 and weekint, within 72 hours after deat 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sykesville c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Months Woodbine d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS Pullen Nursing Home YES NO S 3. NAME OF Middle 4. DATE Lost Month Dov Year DECEASED OF Ivy Pearre (Type or print) Sentember DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH please remove Months Dovs Hours The same Female White WIDOWED DIVORCED the attending physician and sit permit. Then please term 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Frederick Co., Md. Housewife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME crematian, ar remaval, Edward E. Sneake Julia V. Whilhide 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) ((If yes give wor or dotes of service) 15-54-9927 Mr. J. Aubrev Pearre Woodhine. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH Terminal Pneumonia **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gove (b) Cerebral Emboli rise to immediate couse (a). DUE TO stoting the underlying couse as the TO FUNERAL DIRECTOR: After this certificate has been (d) Generalized Parkinsons Disease 10 years 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) CERTIFICATION of Health YES [ NO X Decubitus Ulcers for 20o. ACCIDENT WAS UNDERLYING 20b, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Not While ot work at work shauld be 21. I certify that (1) (this haspital) attended the deceased fram Aug 31 1967, ta Sept 29, 19 67 that (I) (we) last saw the deceased alive on Sent. 16 1967, and that death accurred a8:30 M, from causes and an the date stated above. 22b. DATE SIGNED 220. SIGNATURE ATTENDING 9-29-67 DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Sani Okutman Obrecht Rd. Sykesville. director, 23b. DATE THEREOF 23c. NAME OF CEMETERY CONCENTRAL 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, (County) (Stote) REMOVAL (Specify) Howard Co., Md. Poplar Springs 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR ochanles VR A15 44 DATOCT 2 1967 M. Waltz B ox 241 Sykesville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12269 12258 CERTIFICATE OF DEATH deoth PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY a. STATE b. COUNTY Carroll County Maryland MARYLAND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bal timore ⊇. d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS ON A FARM Klee Mill Guest Home 2401 Calverton Heights Ave. YES NO [ NAME OF Middle 4. DATE Month Doy Year DECEASED Elizabeth (Type ar print) DEATH Sept. 26 1967 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 9. AGE (In years remove 7. MARRIED DATE OF BIRTH **NEVER MARRIED** lest birthday) Manths Doys Hours 7/13/1386 Female White WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during most af working life, even if retired) **INDUSTRY** COUNTRY? Pennsylvania Housewife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ottending physermit. Then p cremotion, or remavo Thomas Gallahgher D. Margaret Long 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yes, no, ar unknown) (If yes give war ar dates of service William Plitt same\_address 18. CAUSE OF DEATH (Enter only one couse per line-) far (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH buriol-transit IMMEDIATE CAUSE (a) signed ! DUE TO Conditions, if ony, which gove rise to immediate cause (a), DUE TO stating the underlying couse **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law re Poge 4 moy be retained by the haspital or attending prior to as the lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUT PERFORMED? NO 20g. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH etached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (City or town) (County) (State) Haur o.m. factory, street, office bldg., etc.) Nat While at wark at work 21. I certify that (I) (this haspital), attended the deseased fram. director, page 3 should should be filed with the FUNERAL DIRECTOR: and that death occurred at by 45M, fram causes and an the date stated above. saw the deceased alive an & 6 22a. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF M.D. DIRECTOR 22c. PHYSICIAN 22d. ADDRESS NAME (Type) 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Baltimore, Md. 0 Loudon Park Cemet. 24. FUNERAL DIRECTOR REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 1967 DATE

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

	12253	9 M	EDICAL	EXAMINER'S	CERTIFICAT	E OF DEAT	H ;	227	0
	1. PLACE OF DEATH	Н		MAN VI AND	a. STATE		b. COUNTY	esidence bei	fore admission)
-	b. CITY OR TOW	/N (If outside corpora and give nearest tov	te limits,	c. LENGTH OF STAY IN 1	c. CITY OR TOWN (I	f outside corporate li	City- mits, write RURAL	and give r	nearest town)
-	Rurel -	Sykesville		2yr 6 mo 7 d	Baltimore d. STREET ADDRESS			e. I	S RESIDENCE
		ld State Ho				lem Avenue		YES	ON A FARM?
	3. NAME OF DECEASED		Irst	Middle	Last	4. DATE OF	Month	Day	Year
4	(Type or print) 5. SEX	MAF 6. COLOR OR RACE		ELIZABETH	RAMSAY 8. DATE OF BIRTH	DEATH	9 years   IF UNDER	10	19 67
	Female	White	WIDOWED	NEVER MARRIED DIVORCED	2-7-1889	iest bli	thday) Months	Days H	lours   Min.
	during most of work	TION (Give kind of work ing life, even if retire	d) IN	IDUSTRY		State or foreign count	C	ITIZEN OF OUNTRY?	WHAT
1	Housewife 13. FATHER'S NAM	B IE			Maryland		1 01	DA.	
1	Levi S	tiner			Helen	Ramsay			
	15. WAS DECEASED	EVER IN U.S. ARMED FO	ORCES? 16. :		. INFORMANT		Address		
-	no				Records, Spr.	ingfield St	ate Hosp	LACTION	a serveral
		EATH WAS CAUSED BY	: Dunam	ne for (a), (b), and (c).]	with multip	le abscesse	S	days	AL BETWEEN AND DEATH
	416 X	IMMEDIATE CAUSE	(0)	iono pridomorra	112011 11012 01201				
1	Conditions, If	any, which \	(b) Rheu	matic and ar	teriosclerot	ic heart di	sease	years	5.
	gave rise to cause (a), s underlying cause	teting the DUE	10						
		significant condition brain sync	ons contribu	TINGTO DEATH BUT NOT RESSOCIATED WIT	LATED TO THE TERMINAL n senile bra	DISEASE CONDITION G in disease	IVEN IN PART 1(a) With	19. W. PE YES	AS AUTOPSY ERFORMED?
	20a. EXTERNA	hotic react L CAUSE WAS CONTRIBUTING D TH.	20b. D	DESCRIBE HOW INJURY OC	CURRED. (Enter nature o	of Injury In Part I or F	art II of Item 18	1 4	
	CAUSE OF DEAT	TH. INJURY Month, Day,	Year   20d If	NJURY OCCURRED   2De. P	LACE OF INJURY (Home, f	arm,   20f. (City or )	(Cou	unty)	(State)
	Hour e.		While	Not While fac	tory, street, office bldg., (		(000	,	(01210)
	21. I certif		-	ains described above, t		Inspection,	Inquiry,	and in	n my opinion
	death result	ted from: Natura	l causes x	, Accident [],	Dicide , Homici		rmined manner		
	ACTUAL SIGNATURE	naurice	CU	Cortinguel	M.D. ASSISTANT ME	EDICAL EXAMINER		22.	DATE SIGNED
	EXAMINER'S NAME (Type)	Maurice C.	Porter	1/		CAL EXAMINER et, city, town, or coun		/	anal 6
2	23a. BURIAL CREM REMOVAL (Sp Burial	MATION, 23b. DATE	THEREOF	23c. NAME OF CEMETE Wester		Edmonde Balto	(City, town or con	unty)	(State)
1	24. FUNERAL DIRI		- + W	ADDRESS 14		C'D BY REGISTRAR			JRE
	11660119	PUL.	OR! //	E. SM 11/1/	ONE DATE O				(/

DIVISION OF STATISTICAL RESEARCH AND RECOR CERTIFICA 24 hours after 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 18 write RURAL and give nearest town) Westminster days papers. Pages in 72 hours aff d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll County General Hospital complete 3. NAME OF DECEASED Middle (Type or print) Henry Harry) Rei and col 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED The law requires that the death certificate be Male WIDOWED White DIVORCED physician 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 1Db. KIND OF BUSINESS OR INDUS Hardware store Retail merchant he hospital or attending physician.
is certificate has been signed by the attending p
for use as the burial-transit permit. Then please 13. FATHER'S NAME Milton Henry Reindollar 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (Ifyes give war or dates of service) 16. SOCIAL SECURITY NO. | 17. 213-14-4481 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO aterioschert Conditions, if any, which gava rise to immediata causa DUE TO (e), stating the underlying causa last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT CERTIFICATION 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCUR MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED I 20a, Pl While Not While Hour a.m. at work at work p.m. 21. | certify that (I) (this hospital) attended the deceased from saw the deceased alive on. 2.3, ......19.6.), and th 22a. SIGNATURE TO HOSPITAL
death. Page
TO FUNERAL
director, page 22c. PHYSICIAN'S NAME (Type) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETER REMOVAL (Specify) Sept. 26.1967 Lutheran Cemetery Burial Taney Lown, Mary Land 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 1SM 7 Taneytown, Maryland

## MARYLAND STATE DEPARTMENT OF HEALTH

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c. CITY OR	TOWN (If o	utside corpo	orate limits, write	e RU	RAL a	nd give	nearest to	wn)
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d. STREET A	DDRESS							RESIDENCE
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OR CREMATORY	12	3d. LOCA	TION (City, to	wn c	or cour	nty)	(5	Stata)
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12262 CERTIFICATE OF DEATH 12273 death. The law requires that the death certificate be executed within 24 haurs after death filled in by the funeral rappers. Pages 1 and 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH and campletely filled in ... Pages I are manye carbon appers. Pages I are o. COUNTY a. STATE b. COUNTY Carroll Maryland MARYLAND c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits. Rural -- Sykesville 7mo. 2days Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 702 E. 23rd St. NO TO NAME OF Middle Lost 4. DATE Month Day Year DECEASED Seletia 19 67 Mand Rickard DEATH (Type or print 6. COLOR OR PACE 8. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 9. AGE (In years 7. MARRIED NEVER MARRIED clast birthdoy) Months Dovs Hours 3/22/17 WIDOWED DIVORCED female Negro 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Georgia USA 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Anna ? George Ponder 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16 SOCIAL SECURITY NO. permit. 0 215-18-9359HA Springfield Hospital records, Sykesville, Md. no crematian, 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED 8Y: INTERVAL BETWEEN ONSET AND DEATH burial-transit Thrombosis left coronary artery IMMEDIATE CAUSE (a) be retained by the haspital or attending physician. DUE TO Coronary arteriosclerosis vears Canditians, if ony, which gave rise to immediate couse (a), DUE TO stoting the underlying couse as the has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)

19. WAS AUTOPSY
Chronic brain syndroms associated with diseases of unknown or undertain PERFORMED? for use YES DE O FUNERAL DIRECTOR: After this certificate Cause Huntington's Chorea with psychotic reaction.

20b. ACCIDEM WAS UNDERLYING | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 200. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Hour o.m. Not While ot work 9/18/ , 19 67, that (\$\text{we}) last 21. I certify that (this hospital) attended the deceased fram. 2/16/ \_\_\_\_, 19.**67**\_\_, ta\_ 1967 and that death accurred at/120 PM, from causes and an the date stated above. 9/18/ saw the deceased alive an. 22b. DATE SIGNED 220. SIGNACURE STAFF PHYS. ATTENDING 9/18/67 M.D. DIRECTOR PHYS 22d. ADDRESS Springfield State Hospital Page 4 may NAME (Type) H. E. Connor. Jr. Sykesville, Maryland director, should to 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 23g. BURIAL CREMATION. 23b. DATE THEREOF REMOVAL (Specify) 2Sb. REGISTRAR'S SIGNATURE 2Sg. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66

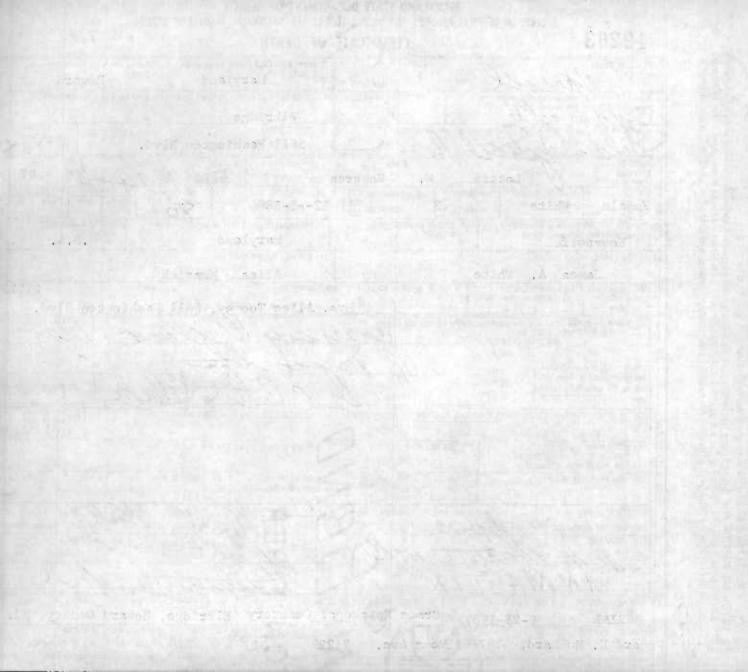
MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before edmission) . COUNTY b. COUNTY Carroll 12 th MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) write RURAL end give nearest town) Westminster weeks Union Bridge, Route 2, hours aft d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS County General Hospital Johnsville complete NAME OF 4. DATE 2 Last Month DECEASED (Type or print) Linnie Trene Savler DEATH September withi 5. SEX 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED and last birthday) Months female WIDOWED IX DIVORCED I Oct certificate 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? & State, or foreign country) done during most of working life, even if retired housekeeper Frederick County, home 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME death Samuel Schwarber Margaret Rowe 15. WAS DECEASED EVER IN U.S. ARMED FORCES? S. Herman Sayler. requires that the 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unknwn) | (If yes give wer or detes of service) Union Bridge, Maryland, no no 1B. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO acute leukemia Conditions, if eny, which gave rise to immediate cause DUE TO (e), steting the underlying (c) PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) | 19. CERTIFICATION 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of injury in Pert I or Pert II of item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, Month, Dev. Yeer 20f. (City or town) (County) factory, street, office bldg., etc.) While Not While Hour e.m. at work et work 23, 1967, and that death occurred at A.M., from the causes and on the date stated above. saw the deceased alive on. 220. SIGNATURE PHYS. DIRECTOR death. Page M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, be filed 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, | 23b. OL Frederick County, Chapel Cemetery 25a. REC'D BY REGISTRAR ADDRESS VR A15 (4) Md. Union Bridge.

12277

. IS RESIDENCE ON A FARM?

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Year

IF UNDER 24 HRS.

2319

Hours

INTERVAL BETWEEN ONSET AND DEATH

WAS AUTOPSY

PERFORMED? NO

(State)

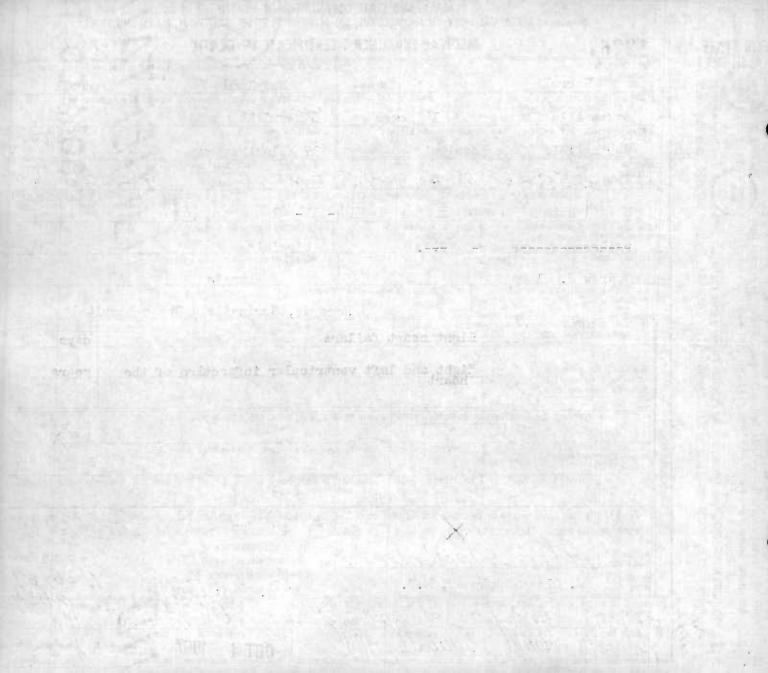
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON, STREET, BALTIMORE, MARYLAND 21201

Them #2a, b, c & d. Film #G393 CERTIFICATE OF DEATH

Tem #9 Film #G393 CERTIFICATE OF DEATH 12279 after-death. law requires that the death certificate be executed within 24 hours after death the attending physician and campletely filled in by the funeral sit permit. Then please remave carbon papers. Pages 1 and 2 USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY MARYLAND b. (ITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) papers. Page hin 72 hours o Carlisle 10vrs9mo2da d STREET ADDRESS IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) County Hond Springfield State Hospital YES NO NAME OF Middle 4. DATE Month First Year DECEASED (Type or print) NMN. SLICHTER 9 19 67 AMOS DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. SFX B./ DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Months Hours 12/27/189/ White WIDOWED DIVORCED and in any Male 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) COUNTRY? INDUSTRY Washington Co, Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Frank Slichter Clara Reed 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 17. INFORMANT 16 SOCIAL SECURITY NO. Address 220-54-6018 Hospital Records INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY Heart failure IMMEDIATE CAUSE (o) signed by DUE TO Arteriosclerotic heart disease Years Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying couse attending as the has been Bronchopneumonia Davs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY PERFORMED? Mental defective, undifferentiated (Microcephaly) YES T NO TO HOSPITAL OR ATTENDING PHYSICIAN: T Page 4 may be retained by the hospital ar a TO FUNERAL DIRECTOR: After this certificate b for 20o. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) Hour o.m. Not While foctory, street, office bldg., etc.) ot work of work 21. I certify that (I) (this hospital) attended the deceased from 12/12/56 . 19 \_\_\_, that (1) (we) last should , and that death accurred at 8:30 M, fram causes and an the date stated above saw the deceased alive on 9/14/67 19 22b. DATE SIGNED 22o. SIGNATURE **ATTENDING** MED. DIRECTOR STAFF PHYS. 9/11/67 directar, page 3 should be filed v M.D. PHYS 27d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Rafi Iqbal, M.D. (County) (Stote) 230. BURIAL TREMATION, 23b DATE THEREOF 23. MAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) REMOVAL (Specify) 24. FUNERAL DIRECTOR 25g. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66 DATE SEP 20

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12280 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death the attending physician and completely filled in by the funeral sit permit. Then please remove carbon papers. Pages I and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) g. COUNTY o. STATE b. COUNTY Carroll Maryland Carroll MARYLAND b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) c LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Tanevtown Tanevtown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO X 65 York Street 65 York Street NAME OF Middle First Lost 4. DATE Month DECEASED (Type or print) Ohler Stambaugh DEATH September Mande 9. AGE (In years lost birthday) SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH Months Hours WIDOWED DIVORCED Female White March 23. 10o. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or fareign country) during most of working life, even if retired) **INDUSTRY** COUNTRY? Housewife Frederick County, Maryland
14. MOTHER'S MAIDEN NAME II.S. Own home 13. FATHER'S NAME Anna C. Shorb John T. Ohler 17. INFORMANT 1S. WAS DECEASED EVER IN U.S. ARMED FORCES 16. SOCIAL SECURITY NO. (Yes, no, ar unknown) (If yes give wor or dates of service) Mrs. Otis Shoemaker, Taneytown, Md. R.D. No INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b) PART I. DEATH WAS CAUSED BY: signed by the burial-transit p IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE JERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? 4 may be retained by the haspital ar for 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II af item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour o.m. factory, street, affice bldg., etc.) Not While at work , 1967, that (1) (we) last 21. I certify that (1) (this hospital) attended the deceased from. . 19 1967, and that death accurred of 130 P. M., from causes and on the dote stoted above. saw the deceased alive on. 22g. SIGNATURE 22b. DATE SIGNED **ATTENDING** M.D. PHYS. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) directar, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) (State) REMOVAL (Specify) Keysville, Carroll, Maryland
REGISTRAR 25b. REGISTRAR'S SIGNATURE Keysville Cemetery Sept. 24.1967 25g. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR 20 M 1/66 Maryland DATESEP Taneytown. .O.Fuss

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 12281 12270 death. requires that the death certificate be executed within 24 hours after death pup PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY b. COUNTY Carroll MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest town) New Windsor Rural DOA Westminster e. IS RESIDENC d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS ON A FARM? Hill Road General Hospital Hawks YES NO X County Middle 4. DATE 3. NAME OF Year DECEASED Leslie Staub. 19 67 (Type or print) Paul DEATH IF UNDER 24 HRS S. SEX 8 DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** lgst birthdoy)
56 yrs. Months Hours WIDOWED DIVORCED Feb. 10, 1911 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired). Iaborer-Md. S INDUSTRY COUNTRY? A. Commission Frederick Co., Md. Roads 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Effie Smith Charles F. Staub 17. INFORMANT AddressR 15. WAS DECEASED EVER IN U.S. ARMED FORCE S? 16. SOCIAL SECURITY NO. .F.D. (Yes, no, or unknown) (If yes give wor or dotes of service) 214-1406898 Elsie S. Staub New Windsor, Md. No 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO X Page 4 may be retained by the hospital or 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 200. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED foctory, street, office bldg., etc.) 1. I certify that (1) (this haspital) attended the deceased fram. , 19\_\_\_\_, ta\_ , 19\_\_\_, that (i) (we) last M, fram causes and an the date stated above. and that death accurred at\_\_\_ saw the deceased alive an 22b. DATE SIGNED 220 SIGNATURE MED. DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Westminster. Md. Wilkens Reese shauld 230. BURIAL, CREMATION, REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (County) (Stote) MEADOW BRANCH (EMETER NESTMINSTER 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Charles INDSOR DATSEP 136/

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12282 12271 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Carroll MARYLAND Maryland Maryland Mont.comery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b Silver Spring Rural - Sykesville vr. 19 da. d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) e. IS RESIDENCE ON A FARM? 11636 Lockwood Drive NO x Springfield State Hospital 3. NAME OF Middle 4. DATE Lost Year DECEASED ROSS STINE (Type or print) WILLIAM September 15 **OEATH** 6. COLOR OR RACE S. SEX 8. DATE OF BIRTH 9. AGE (In years IF UNOER 1 YEAR IF UNDER 24 HRS. 7. MARRIEO NEVER MARRIED lost birthdoy) Months Doys Hours WIDOWED DIVORCED Male White 1-24-1892 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, eyen if retired work to w COUNTRY? Kanawha Co., W. Virginia
14. MOTHER'S MAIDEN NAME IISA 13. FATHER'S NAME Ross W. Stine Virginia Cracraft 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, na, ar unknown) (If yes give war ar dates of service) 215-20-3376 Records, Springfield State Hospital 18. CAUSE OF OEATH (Enter only one cause per line far (a), (b), ond (c).)
PART 1. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) **OUE TO** Conditions, if any, which gave rise to immediate cause (o), DUE TO stating the underlying cause last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NO 20a. ACCIDENT W/S UNDERLYING 20b. OESCRIBE HOW INJURY OCCURREO. (Enter nature of injury in Part 1 or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20c. TIME OF INJURY Month, Day, Year (City or town) (County) (State) factory, street, affice bldg., etc.) at wark at wark 21. I certify that (4) (this haspital) attended the deceased from August 26., 19.66, to Sept. 15, 19.67, that (b) (we) last 19 67, and that death accurred at \$15PM, fram couses and on the date stated above. saw the deceased olive an Sent. 22a. SIGNATURE 22b. DATE SIGNED 9-15-67 M.D. 22d. ADDRESS Springfield State Hospital

23c. NAME OF CEMETERY OR CREMATORY

Maplewood Cemetery

Sykesville, Maryland

23d LOCATION (City or Town)

Kingwood.

2Sa. REC'D BY REGISTRAR

DATE SE

(County)

West Virginia

2Sb. REGISTRAR'S SIGNATURE

(State)

24 hours ofter deoth filled in by th papers. Pagithin 72 hours OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within ove carbon event, with and rem or removal, os the prior to this certificate hos been the hospital After be retoined TO FUNERAL DIRECTOR:

NAME (Type) Agustin del Campo

23a. BURIAL, CREMATION,

23b. DATE THEREOF

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 12283 I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before edmission) e. COUNTY b. COUNTY Carroll Maryland MARYLAND b. CITY OR TOWN (if outside corporata limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL and give neerest town) write RURAL and give nearast town) Union Bridge Union Bridge vears d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS . IS RESIDENCE ON A FARM? 21 W. Broadway YES NO TY Broadway NAME OF 4. DATE Middle DECEASED (Type or print) DEATH Oscar William Strawsburg 19 67 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS and last birthday) Months ē WIDOWED [ DIVORCED 10a. USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) laborer Frederick Co. Md. U.S.A. farmer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John W. Strawsburg Elizabeth Harris 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unkown) | (If yes give war or dates of service) Edith D. Strawsburg Union Bridge, Md. 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c) INSET AND DEATH PART I. DEATH WAS CAUSED BY: oRonaus nous IMMEDIATE CAUSE (e) geve rise to immediata cause DUE TO (a), steting the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) | 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO X 2Db. DESCRIBE HOW INJURY OCCURED, (Enter neture of injury in Pert I or Pert II of item 18.) 2De. ACCIDENT WAS UNDERLYING IT OR CONTRIBUTING CAUSE OF DEATH MEDICAL 20c. TIME OF INJURY 2Dd. INJURY OCCURRED 20e, PLACE OF INJURY (Home, ferm, (Stete) 2Df. (City or town) (County) Month, Day, Yeer factory, street, office bldg., etc.) While Not While Hour a.m. et work et work n.m. .7., 19....., that (I) (we) last 19......, and that death occurred a D.M. from the causes and on the date stated above. saw the deceased alive on 22b. DATE 22a, SIGNATURE ATTENDING SIGNED DIRECTOR PHYS. M.D. JN1 On 22c. PHYSICIAN Bridge, Md. Caricofe director, be filed 23e. BURIAL, CREMATION. | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Stete) REMOVAL (Specify) 0 Pipe Creek Cemeterv Carroll Buria. Md FUNERAL DIRECTOR'S SIGNATURE ADDRESS UNION 250, REC'D BY REGISTRAR 256, REGISTRAR'S SIGNATURE VR A15

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12273 CERTIFICATE OF DEATH 12284 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STAT Maryland b. COUNTY Balt. City Carroll MARYLAND the death certificate be executed within 24 haurs after b. CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 1h c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) papers. Pag hin 72 hours ( write RURAL and give nearest town) Baltimore Sykerville Lv. 3m.7d. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) = d. STREET ADDRESS e. IS RESIDENCE ON A FARM? filled 2703 The Alamedae UIL Springfield State Hospital YES NO T NAME OF ove texbon Middle DATE Month Lost Dov Year campletely DECEASED September 19 67 Arthur Herbert. Sturgeon event, (Type or print) DEATH IF UNDER 24 HRS AGE (In years IF UNDER 1 YEAR S. SEX 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED lost birthdoy) Months Dovs Hours 5-30-88 Male White and in agy WIDOWED DIVORCED and 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT physician a during most of working life, even if retired) Retired COUNTRY? Maryland USA 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Emma Douglas George Sturgeon Hecords Springfield State Hospital, Sykesville, Md. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (It yes give war or dates of service) cremation, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit p burial, cremati ONSET AND DEATH PART I. DEATH WAS CAUSED BY requires that IMMEDIATE CAUSE (o) Acute Heart Failure davs DUF TO Bilateral pneumonitis Conditions, if ony, which gove davs rise to immediate cause (o). DUF TO stoting the underlying couse the ir to has been Arteriosclerotic cardiovascular disease ATTENDING PHYSICIAN: The law vears PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) PSYCHOTIC reaction. as 19. WAS AUTOPSY PERFORMED? far use Health CERTIFICATION NO TY certificate 20g. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (Stote) 20c. TIME OF INJURY Month, Dov. Year (City or town) (County) Hour o.m. foctory, street, office bldg., etc.) Not While a After ot work 1966 9-7-1967, that (1) (we) lost 21. I certify that (1) (this haspital) attended the deceased from 2-1be retained 19 67, and that death accurred at6:20pM, from causes and on the date stated above. TO FUNERAL DIRECTOR: sow the deceosed olive on 220. SIGNATURE 22b. DATE SIGNED 9-7-67 director, page 3 shauld be filed v M.D. DIRECTOR Springfield State Hospital 22c. PHYSICIAN'S O HOSPITAL NAME (Type) Carlos G. Lavin, M. D. Sykesville, Md. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 23o. BURIAL CREMATION. (County) REMOVAL (Specify)
Burial Baltimore National Baltimore Md SISTRAR 256. REGISTRAR'S SIGNATURE Cent. 25o. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 HENRY SANDER & SONS. INC. Baltimore Md.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 12285 death. puo I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY CO . CARROLL
c. CITY OR TOWN (If autside exparate limits, write RURAL and give nearest tawn) CARROLL MARYLAND b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 16 write RURAL and give nearest town) WESTMINSTER d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) requires that the death certificate be executed within 24 hou d STREET ADDRESS attending physician and completely filled in sermit. Then please remove carbon papers. e. IS RESIDENCE ON A FARM? 228 PENNA AUE. CARROLL Co. NO Z NAME OF Middle First 4. DATE Manth DECEASED (Type or print) DEATH SEX IF UNDER 24 HRS. 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED last birthday) Manths MALE AUG: 27 1907 WIDOWED DIVORCED IOa. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? MASTER MECHANIC FLOOR COVERING PLANT MESTMINSTER 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME LICLARK TAYLOR MARY AGNES KNIG 16. SOCIAL SECURITY NO 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na. ar unknown) (If yes give war ar dates of service) 7837 MRS-CLYDE H- TAYLOR INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: ARDIAC IMMEDIATE CAUSE (a) þ DUE TO signed buriol-1 ACUTE MYOCARDIAL HOURS Canditians, if any, which gave rise to immediate couse (a), DUE TO stating the underlying cause TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Poge 4 may be retained by the hospital or ottending TO FUNERAL DIRECTOR: After this certificate has been 9 os the RTERIOSCLEROTIC HEBET WAS AUTOPS' PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? use CERTIFICATION Heolth NO F far 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City ar town) (County) (State) factory, street, affice bldg., etc.) Nat While at work e deceased fram 9/14, 1962, ta , 19, , that (I) (we) last 1962, and that death accurred at 456 M, from causes and on the date stated above. 21. I certify that (I) (this haspital) attended the deceased fram. , 19\_\_\_, that (I) (we) last saw the deceased alive on 22a. SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, plnods 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, 23d. LOCATION (City or Tawn) (County) (State) REMOVAL (Specify) LEISTERS CEMETERY RURAL, WESTMINSTER 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 Charles

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12286 CERTIFICATE OF DEATH be executed within 24 hours after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give peorest town) LIKESU e. IS RESIDENCE ON A FARM? NAME OF HOSPITATOR INSTITUTION (If not in hospital, give street oddress) YES NO X NAME OF First Middle DATE Doy DECEASED OF DEATH AMes (Type or print) 1967 ar remayal, and in any event SEX 6. COLOR OR RACE AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED DATE OF BIRTH lost birthdoy) Months Dovs Hours WIDOWED DIVORCED pup COUNTRY? 5. A 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) physician ( INDUSTRY requires that the death certificate LADORER LUMBER 13. FATHER'S NAME 14. MOTHER'S MAIDEN 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no orunknown) (If yes give wor or dotes of service) 216-14-5703 burial, crematian, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH Coronary thrombosis, acute: Cardiac failure: IMMEDIATE CAUSE (o) ... DHE TO March 1967 Conditions, if ony, which gove Emphysema: Arteriosclerosis, generalized: through rise to immediate cause (o), 9/4/67 DUF TO stoting the underlying couse as the has been with arteriosclerotic heart disease. 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) O HOSPITAL OR ATTENDING PHYSICIAN: The PERFORMED? YES NO X certificate 2Do. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Yeor 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) 2Dd. INJURY OCCURRED (County) TO FUNERAL DIRECTOR: After this Hour o.m. foctory, street, office bldg., etc.) Not While ot work ot work 21. I certify that (1) (this haspital) attended the deceased from March 1967 to 9/4/ saw the deceased glive an Sept. 4. 19 67, and that death accurred at 7:30 Mafram causes and an the date stated above 22b. DATE SIGNED 22o. SIGNATURE ATTENDING STAFF PHYS. 9/5/67 director, page 3 shauld be filed v M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Howard E. Hall, M.D. Sykesville, Maryland BURIAL CREMATION. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) FUNERAL DIRECTOR 2So. REOD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 Charle

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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JING PHYSICIAN by the hospital of ther this certifical be detached for State Dept. of He.	MEDICAL	20c. TIME OF INJUR	Y Manth, Day, Year	20d. IN	JURY OCCURRED		CE OF INJURY (Home, farm,	20f.	(City ar town)	(Cour	ity)	(State)
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AL OR ATTEN y be retained L DIRECTOR: A age 3 should filed with the		22c. PHYSICIAN'S	- UX-A	1	The	engine	22d. ADDRESS					27
may be RAL DIII		NAME (Type)	Naci n.	Buvuku	nsal, M.D.			Sykes	gfield s	Mary La	ad 217	81.
TO HOSPITAL OR ATTENDING Page 4 may be retained by t TO FUNERAL DIRECTOR: After director, page 3 should be c should be filed with the Stark	230	BURIAL, CREMATION			23c. NAME OF CEME	TERY OR	CDEMATORY		ATION (City or To		County)	(State)
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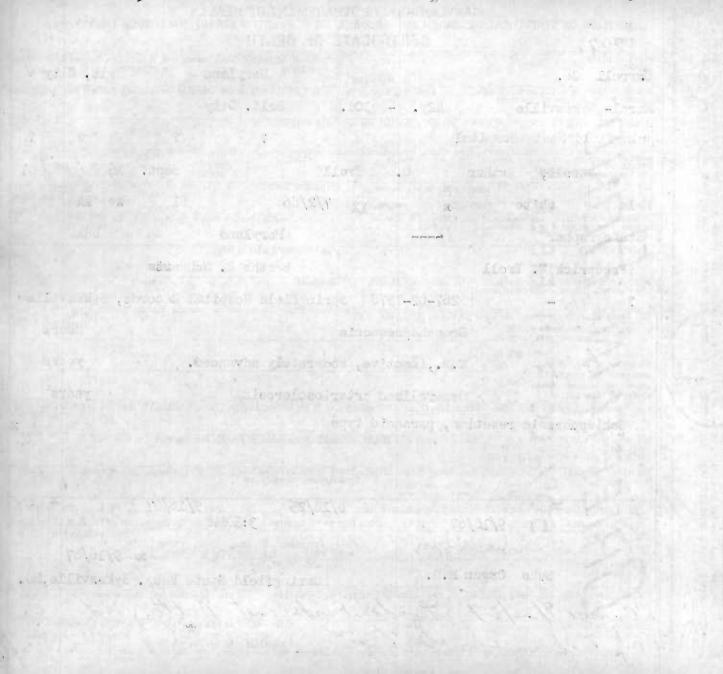
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AI5 (4) 2DM 1/65

	MARYLAND STATE DEPARTMENT OF HEALTH	
DIVISION OF STAT	TISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, M	
12277	CERTIFICATE OF DEATH	12288

1	a CDUNTY Carroll Co. MARYLAND	a. STATE Maryland b. COUNTY Balt	
	b. CITY OR TDWN (if outside corporate limits, write RURAL and give nearest town) Rural-, Sykesville  C. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL Balt. City	
2	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) Springfield State Hospital	d. STREET ADDRESS	e. IS RESIDENCE DN A FARM? YES NO
1	NAME OF First Middle DECEASED (Type or print) Arthur O. Tro.	Last 4. DATE Month OF DEATH Sept. 16	Day Year 19 67
	Male: white WIDOWED TO DIVORCED DIVORCED	7/2/86  9. AGE (In years   IF UNDER: Months   Works   Works	Hours Min.
100	Da. USUAL OCCUPATION (Give kind of work done uring most of working life, even if retired)  stenographer	11. BIRTHPLACE (County & State, or foreign country)   12. Cl	TIZEN OF WHAT UNTRY? JSA
	3. FATHER'S NAME Frederick N. Troll	14. MOTHER'S MAIDEN NAME  Bertha E. Schwatts	
(	Yes, no. or unkown) (If yes give war or dates of service)	INFORMANT Address pringfield Hospital Records, Sy	kesville
	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), end (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH HOUTS
	gave rise to immediate cause (a), stating the DUE TO	oderately advanced.	years
MOTEOTO	underlying cause last. ) (c) Generalized arte: PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE PART II. OTHER SIGNIFICANT CONTRIBUTIONS CONTRIB	TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED?
		RRED. (Enter nature of Injury In Part I or Part II of Item 18.)	
MAINTE	20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20e. PLAC   Hour a.m.   While   Not While   at work	CE DF INJURY (Home, farm, 2Df. (City or town) (Courry, street, office bidg., etc.)	nty) (State)
	21. I certify that (this hospital) attended the deceased from 8	death occurred at 3.2 50 M from the causes and on the	, that (1) (we) last the date stated above. THE SIGNED
	22c. PHYSICIAN'S NAME (Type) Suha Ozgun M.D.	22d. ADDRESS Springfield State Hosp. Syke	
-	3a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF GEMETERY EMOVAL (Specify) 9/20/67 Lyndon / 24. FUNERAL DIRECTOR ADDRESS	OR CREMATORY 23d. LOCATION (CLLY, town or could be completed by REGISTRAR) 25b. MEGISTRAR'S DATE OF 2 2 1967	SIGNATURE
	ing. I will and and or of the	J DAIDS ST	4



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HEALTH DEF	T. ≘		Carro	11			MARYLAND	o. STATE		here deceosed lived	b. COUNTY	n: Residence befo	
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es 1, 2, farm farm form	aurs of	(	I. NAME OF HOSPITA	L OR INSTITUTION (If no eld State		ALTERNATION OF THE PARTY	s)	d. STREET A	ADDRESS	ine Ave.			e IS RESIDENCE ON A FARM? YES NO X
dea with	22	[	NAME OF DECEASED Type or print)	Fi	rst HIN	Midd THON		Last		4. DATE OF DEATH	Month	EMBER 1	y Year
18. Give e along v	3	S. S	Contract of the Contract of th	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MA	ARRIED	8. DATE OF B	IRTH	9. AGE (	in years		IF UNDER 24 HRS.
24 haurs in Item I r's Office	any ever	10o. duri	USUAL OCCUPATION ng most of working li Carpent		10b. KI	ND OF BUSINESS IDUSTRY	OR	New 3		r foreign country)		12. CITIZEN COUNTRY	?
within pencil camine	.⊆		FATHER'S NAME  John Wad					14. MOTHER DE	R'S MAIDEN NA	. Thorne			
	removal, a	1S. (Ye:	WAS DECEASED EVER s, no, or unknown) No	IN U.S. ARMED FORCES? If yes give wor or dotes o	of service) 16.	SOCIAL SECURITY  5-30-295		cords,	Spring	gfield St	Address tate H		
	0		PART 1. DEATH	ATH (Enter only one cou I WAS CAUSED BY: IMMEDIATE CAUSE	A 1	(a), (b), ond (c).						IN O	NTERVAL BETWEEN ONSET AND DEATH Minutes
war the trial-	crematian,		Conditions, if ony, rise to immediate	which gove couse (o),	(b) Occ.	lusion o	of lary	nx by	food				Minutes
fic. ing ing	burial, cre		stoting the underlost.	ying couse S	(c)	TO DEATH BUT NO	OT PELATED TO	THE TERMINAL	DISEASE COND	UTION CIVEN IN PA	APT 1/o)	110	WAS ALITOPSY
hi: e e be	10	CERTIFICATION	Involuti 200. EXTERNAL CAL	onal psych	otic r	eaction				ort I or Port II of i			P. WAS AUTOPSY PERFORMED? YES X NO
4	nt, priar	A	PRIMARY Tor CON CAUSE OF DEATH.  20c. TIME OF INJUI			NJURY OCCURRED		ACE OF INJURY			or town)	(County)	(Stote)
Page No.	ogent,	MED	1:05 P.m	9-13 19 that I took chorge	67 While	k U ot work		eld an Auto		Inspection	). Inquir	v D, an	id in my apiniai
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TO DEPUTY necessary, the funeral 5 may be TO FUNERAL	Health	230.	BURIAL, CREMATION  BURIAL, CREMATION  BENOVAL (Specify)	Glenn Spe N, 23b. DATE THI 9-16	EREOF	23c. NAME OF	CEMETERY OR			23d. LOCATION	City or Town		
VR A15ME	M		FUNERAL DIRECTOR			ADDRES	S		2So. REC'D	BY REGISTRAR	2Sb. REGIS	STRAR'S SIGNATU	JRE

BOOK THE CONTRACT OF RESERVOIR STREET, The state of the s OFTEN STATE an make which process in the constant of the c nurtain deller Codes than her anti Material Control Minist Dunered Lange, Langertown, S. Core Lot Williams

b. CITY OR TOWN (if autide corporate limits, write RURAL and give nearest fown, and the RURAL and give nearest fown, and the RURAL and give nearest fown, and the RURAL and give nearest fown and the RURAL and give rest fown and the RURAL and give rest fown and the RURAL and give nearest fown and give nearest		DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  CERTIFICATE OF DEATH  12291
d, NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give streat address)  d, STREET ADDRESS  A, STREET ADDRESS  A, STREET ADDRESS  A, STREET ADDRESS  A, STREET ADDRESS  B, SER  B	1.	e. COUNTY  CARROLL CO. MARYLAND  b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
S. NAME OF DECEASED (Type or print)   Deceased	-	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  d. STREET ADDRESS  d. STREET ADDRESS  e. IS REST
S. SEX	3	NAME OF First Middle Last 4. DATE Month Dey Year DECEASED OF
The property of the property		5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED   8. DATE OF BIRTH FEMALE WIDOWED DIVORCED JAN. 25 1888 9. AGE (In yeers   If UNDER 1 YEAR   If UNDER 2.    Hours   7. Married North Deys   1888 9. AGE (In yeers   If UNDER 1 YEAR   If UNDER 2.    Hours   7. Married North Deys   1888 9. AGE (In yeers   If UNDER 1 YEAR   If UNDER 2.    Hours   7. Married North Deys   1888 9. AGE (In yeers   If UNDER 1 YEAR   If UNDER 2.    Hours   7. Married North Deys   1888 9. AGE (In yeers   If UNDER 1 YEAR   If UNDER 2.    Hours   7. Married North Deys   1888 9. AGE (In yeers   If UNDER 1 YEAR   If UNDER 2.    Hours   7. Married North Deys   1888 9. AGE (In yeers   If UNDER 1 YEAR   If UNDER 2.    HOURS   7. Married North Deys   1888 9. AGE (In yeers   If UNDER 1 YEAR   If UNDER 2.    HOURS   7. Married North Deys   1888 9. AGE (In yeers   If UNDER 1 YEAR   If UNDER 2.    HOURS   7. Married North Deys   1888 9. AGE (In yeers   If UNDER 1 YEAR   If UNDER 2.    HOURS   7. Married North Deys   1888 9. AGE (In yeers   If UNDER 1 YEAR   If UNDER 2.    HOURS   7. Married North Deys   1888 9. AGE (In yeers   If UNDER 1 YEAR   If UNDER 2.    HOURS   7. Married North Deys   1888 9. AGE (In yeers   If UNDER 1 YEAR   If UNDER 2.    HOURS   7. Married North Deys   1888 9. AGE (In yeers   If UNDER 1 YEAR   If UNDER 2.    HOURS   7. Married North Deys   1888 9. AGE (In yeers   If UNDER 1 YEAR   If UNDER 2.    HOURS   7. Married North Deys   1888 9. AGE (In yeers   If UNDER 1 YEAR   If UNDER 2.    HOURS   7. Married North Deys   1888 9. AGE (In yeers   If UNDER 2.    HOURS   7. Married North Deys   1888 9. AGE (In yeers   If UNDER 2.    HOURS   7. Married North Deys   1888 9. AGE (In yeers   In yeers   If UNDER 2.    HOURS   7. Married North Deys   1888 9. AGE (In yeers   In yeers   In yeers   If UNDER 2.    HOURS   7. Married North Deys   1888 9. AGE (In yeers   In ye
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or deleas of service)  27 05 78805 MR, EDGAR R. WARD, ADDRESS  18. CAUSE OF DEATH (Enter only one cause of tine for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: (b)		HOUSE - WIFF - CARROLLCO-MD.
IB. CAUSE OF DEATH [Enter only one cause cyt line for (a), (b), and (c).]   PART I. DEATH WAS CAUSED BY:	1 (	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  Yes, no, or unknown) ((Ifyes give wer or detes of service)
20c. TIME OF INJURY Month, Day, Year Hour e.m. While at work of the deceased from 19 at the deceased alive on 19 and that death occurred to 3 M, from the causes and on the date stated 22 FIGNATURE  20c. TIME OF INJURY (Home, farm, 20f. (City or town) (County) (Factory, street, office bldg., etc.)  21. I certify that (I) (this hospital) attended the deceased from 10 m, 19 (5 to 4 pleases 27 19 m, that (I) (the saw the deceased alive on 19 m and that death occurred to 3 M, from the causes and on the date stated 22 of GNATURE  22c. PHYSICIAN'S ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. 19 - 27 - 6 22 of ADDRESS	NO	Conditions, if eny, which gave rise to immediate cause (a), steting the underlying cause lost.  (b) Usteriasclinas — Severe General Conditions (b) (b) Conditions (c) (c) (c) (c)
21. I certify that (I) (this hospital) attended the deceased from 1. Loury	CERTIFICAT	YES NO YES NO YES NO YES NO NOTIFY MEDICAL EXAMINER)
saw the deceased alive on	MEDICAL	20c. TIME OF INJURY Month, Day, Year Hour e.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (S
22c. PHYSICIAN'S EMCLEARING M.D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. PHY		saw the deceased alive on
		Classice & Malleans M.D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS.

CARROLL GO MARKED CARROLLIA NESTMINISTER REXT 29 HE NESTONGTHER ROWG (32337x) ( FEESE ) NORMA PIARD 5507 27 ELLER 22 HOW 37 MINES -JAN 25 1888 70 CARRELECOMD 2012-10 HOUSE - NURE JOHNATHAN MONATH ELLEN ALCHES TITUS THE MEDGER R WARD, APPRESS TORING - E/ 30/127 CARROLLIZED CHURCH CFG4) PENNERGING RID MA As myster for producinte mile age of 1881 order france.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
19981 CERTIFICATE OF DEATH

-	The fee U.A.					12232
	1. PLACE DF DEATH a. CDUNTY	. 1.	arrott te	2. USUAL RESIDENCE (	Where deceased lived, If instit	tution: Residence before admission)
	Carr	coll County	MADVIANO	a. STATE Mary	land b. COUNTY	Montgomery
-	the second second	f outside corporate limits.	MARYLANO  1 c. LENCTH OF STAY IN 1b			RURAL and give nearest town)
100	write RURAL and	give nearest town)	2 - 1	Chevy C		KORAL and give hearest town)
-	Sykesvi	ILE	duglars		mase	15 1
90	u. MOVIE OF HOSPIT	AL OR INSTITUTION (if not in	nospital, give street address)	d. STREET AODRESS		e. IS RESIDENCE ON A FARM?
-	Tullew	nursexa Na	me & FIRST AVE.	203 Prin	arose Street	YES NO E
Y	3. NAME OF	/First	Middle	Last 4.		Oay Year
	(Type or print)	HLTH Matl	newson	ATERS	DEATH Soul	7 13 1967
1	5. SEX 6.	COLOR OR RACE   7. MARRIE	NEVER MARRIED	B. OATE OF BIRTH	9. ACE (In years IF	UNDER TYFAR UF UNDER 24 HRS
	F	HITE WIDOWE		4-19-1880	last birthday) M	onths   Oays   Hours   Min.
-	10a, USUAL DCCUPATION	(Cive kind of work done   10b.			y & State, or foreign country)	12. CITIZEN OF WHAT
	during most of working I	life, even If retired)	INDUSTRY			COUNTRY?
-	Housewife	3		Washingto		U.S.
	13. FATHER'S NAME	0		14. MOTHER'S MAIOEN		
	Allis	on C. Jenl	kins	Helen Ma	atnewson	
	15. WAS DECEASED EVER	RIN U.S. ARMED FORCES? 16 yes give war or dates of service)	S. SOCIAL SECURITYNO.   17.	INFORMANT	Address	
	No		15-54-7429 Nu	rsing Home	records San	e as Item L.
=		TH [Enter only one cause per	line for (a) (b) and (c) ]	Tattik Home	records	INTERVAL BETWEEN
		WAS CAUSED BY:	Time to (a), (b), and (c).	100.0		ONSET AND DEATH
	16201	MMEDIATE CAUSE (a)	Colona	1 Verc	under	1931
	7 701	DUE TO	, 0	1- 41	. 17	
24	Conditions, If any, gave rise to Imr		"Unter	EN MAN	carner.	11/0
	cause (a), statin		1) 1	0 1	>011	6
	underlying cause la		01.181	Xx Reles	o College	X-x -1-
	PART II. OTHER SICN  20a. ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY	IFICANT CONDITIONS CONTRIE	BUTING TO DEATH BUT NOT RELA	TEO TO THE TERMINAL DISE	ASE CONDITION CIVEN IN PA	RT1(a) 19. WAS AUTDPSY
	CAI					PERFORMED?
	20a. ACCIDENT WAS	UNDERLYING   20b.	DESCRIBE HOW INJURY OCCU	RREO. (Enter nature of Inl	ury In Part I or Part II of I	
	OR CONTRIBUTING	CAUSE DF DEATH MEDICAL EXAMINER)				
			INJURY OCCURRED   20e. PLA	CE OF INJURY (Home, farm,	20f. (City or town)	(County) (State)
	20c. TIME DF INJU	While	facto	ry, street, office bldg., etc.)	201. (Gity of town)	(Gounty) (State)
1	p.m.	19 at wo				
	21. I certify th	at (I) (this hospital) aftend	ded the deceased from	hard 9, 198	5, to A 11-13	, 19 47, that (I) (we) last
	saw the deceas	sed alive on State	1/219 6 7 and that	death occurred at 1/6	M. from the causes ar	d on the date stated above.
	22a. SICNATURE		1			22b. DATE SICNED
	1/1/	MAGTE	√~ M.O	ATTENDING MED DIRE	ECTOR PHYS.	09/13/67
	22c. PHYSICIAN'S	111111111111		22d. ADDRESS	1	911.0101
	NAME (Type)	CML91	1/4	Mry I	mester	- Mil
	23a. BURIAL, CREMATIC	ON.I 23b. DATE THEREOF	23c. NAME OF CEMETERY	OP CPEMATORY	23d. LOCATION (City, town	n or county) (State)
1	REMOVAL (Specify	)	~			
1	Cremation 24. FUNERAL DIRECTO		AOORESS	Crematory	Suitland.	Maryland
1	ROBERT A		ethesda, Mary	land CF	BY REGISTRAR 256. REG	THE STATE OF THE S
10		7	y and y	TO THE OLD	~ //	// 0

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

VR AI5 (4) 20M 1/65 THE REPORT OF THE PARTY OF THE Manual Control installing and the second THE REPORT OF THE PARTY OF THE middle gent of the property of the second rectaching to the property of 

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12282 72293 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH o. COUNTY o. STATE MARYLAND 24 hours after b. CITY OR TOWN (If outside carparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) .⊆ d. STREET ADDRESS IS RESIDENCE ON A FARM? Liberty bertu ROAD YES NO X 3 NAME OF Middle DATE Manth Day Year DECEASED OF DEATH 19 event, (Type or print) executed AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED DATE OF BIRTH birthday) Manths Hours and in any WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT requires that the death certificate be during most of working life, even if retired) ecretary 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME signed by the attending physi burial-transit permit. Then pl burial, crematian, or remaval, CONA 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, np, grunknawn) (If yes give war ar dates of service) 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY Cardiac failure, renal failure, IMMEDIATE CAUSE (a) DUF TO 1964 Conditions, if ony, which gove Bronchial pneumonia. through rise to immediate cause (o). DUE TO 9/27/67 has been s ise as the t th priar to b stoting the underlying cause Severe emphysema and anemia. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPSY PERFORMED? far use Health NO X ATTENDING PHYSICIAN: 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Dept. of (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d INHIRY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Haur a.m. factory, street, affice bldg., etc.) of work of work TO FUNERAL DIRECTOR: After 21. I certify that (I) (this haspital) attended the deceased fram 1964, 19, to Sept. 27, 19, 67, that (I) (we) las saw the deceased alive an Sept. 27, 19, 67, and that death occurred at 5:30 M, fram causes and on the date stated obove director, page 3 should should be filed with the 22a. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. Sept. 28, 167 M.D. DIRECTOR PHYS 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Sukesville, Maryland Howard E. Hall. M.D. BURIAL, CREMATION 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY (County) (Stote) REMOVAL (Specify) BUTIAL 2Sa. REC'D BY REGISTRAR FUNERAL DIRECTOR VR A15 (4) 25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH

Start Con el wurdtyn. Laytonsville Mont. No.  MARYLAND STATE DEPARTMENT OF HEALTH